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IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in a case involving a market-dominant physician-owned "health maintenance organization" ("HMO") that had extraordinarily high prices and profits, engaged in geographic division of markets, faced no significant HMO competition, and had effectively excluded a potential competitor that would have lowered HMO prices by twenty percent, the Seventh Circuit correctly overturned a jury finding of monopolization based on the court's view that there is no separate product market for "HMO services."

2. Whether, in a case where affiliation agreements between a market-dominant physician-owned HMO and nearly all of the region's remaining physicians required such physicians to reduce their lucrative compensation from the dominant HMO if they accepted lower offers from another HMO, and those agreements were buttressed by numerous other predatory and concerted actions designed to maintain the dominant HMO's market position, the Seventh Circuit correctly overturned jury findings of monopolization and conspiracy to monopolize based primarily on the court's preconceived views regarding economics and competition.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") and Compcare Health Services Insurance Corporation ("Compcare") seek review of a decision of the United States Court of Appeals for the Seventh Circuit vacating most of an antitrust judgment entered in their favor after a jury trial.[1]

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[1] All parties in the court below are listed in the caption. Blue Cross and Blue Shield United of Wisconsin is a Wisconsin corporation with a partial ownership interest in United Wisconsin Services, Inc., a publicly traded Wisconsin company. Compcare Health Services Insurance Corporation, a Wisconsin company, is wholly owned by United Wisconsin Services, Inc.

OPINIONS BELOW

The opinion of the Court of Appeals, as modified on rehearing, is reported at 65 F.3d 1406 (7th Cir. 1995), and, as first issued, is reproduced at Pet. App. 1a. The order denying rehearing but modifying the opinion is reproduced at Pet. App. 64a.

The memorandum opinion and order of the District Court, granting in part and denying in part defendants' motion for judgment as a matter of law, denying defendants' motion for a new trial on liability, denying defendants' motion for a new trial on damages conditioned upon plaintiffs' acceptance of a remittitur, and granting plaintiffs injunctive relief, is reported at 883 F. Supp. 1247 (W.D. Wis. 1995), and is reproduced at Pet. App. 21a.

JURISDICTION

The decision of the court of appeals was issued on September 18, 1995. The order of the court of appeals, denying the request for rehearing but modifying the original opinion, was issued on October 13, 1995. The Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2, are reproduced at Pet. App. 77a.

STATEMENT

This is an action under Sections 1 and 2 of the Sherman Act in which the jury found that respondent, The Marshfield Clinic ("Marshfield"), engaged in a wide range of unlawful monopolistic and conspiratorial conduct in furtherance of its corporate mission of becoming "*the* health care system for Wisconsin and Michigan's upper peninsula."[2] The evidence at trial showed that

[2] Trial Exhibit ("Tr. Exh.") 1983 (emphasis in original). This goal was stated in a corporate "mission statement" adopted by Marshfield on February 17, 1987. Fritz Wenzel, Marshfield's Execu-

Marshfield had substantially achieved its goal. Marshfield Clinic itself employs more than 400 physicians in 22 sites throughout north-central Wisconsin. (Pet. App. 2a.) Its HMO—Security Health Plan of Wisconsin, Inc. ("Security")—has 90 percent of the HMO enrollees in nine Wisconsin counties. (Pet. App. 3a, 18a, 27a.) Security has affiliation agreements with 900 physicians, who constitute virtually all the remaining physicians in the region not employed by Marshfield. (*See* Tr. 746-50; Tr. Exh. 10222, 10344-52.) In fact, *all* of the physicians in 13 cities and two entire counties are either Marshfield employees or Security affiliates. (*See* Tr. 713-15.) Finally, Marshfield owns, or controls through its partner Ministry Corporation, seven hospitals, including the largest in the region. (Tr. 195-96.)

Petitioner Compcare, a subsidiary of petitioner Blue Cross, is an HMO that found out how aggressively and effectively Marshfield protects its dominant position. Compcare is typical of the HMOs that are restructuring the national health-care system. It offers consumers a significantly different package of benefits from traditional health insurance plans, and its substantially different cost structure permits it to charge a significantly lower price than traditional health insurers. (Pet. App. 24a-25a; *see also* Tr. 63-64, 70, 343-44, 699-711, 1114-20, 1142-43.) Compcare saw an excellent opportunity to expand into Marshfield's territory, where Security faced no HMO competition and therefore charged far more than an HMO would normally charge, resulting in bloated profits.[3]

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tive Director, acknowledged at trial it was his view that health care should be a monopoly. Trial Transcript ("Tr.") 1362. Marshfield operates as a tax-exempt organization and is one of the largest clinics in the United States with annual revenues of nearly a quarter of a billion dollars. (Pet. App. 2a; *see also* Tr. 711.)

[3] Marshfield's physician prices exceeded statewide averages by 30% (Tr. 132, 151; Tr. Exh. 53) and exceeded those of 90% of all other physicians in the State of Wisconsin (Tr. 127-30, 160-71, 766-69; Tr. Exh. 59). Security, though licensed as an HMO, priced

Marshfield was aware that Compcare intended to charge HMO subscribers substantially less than Marshfield or Security charges. (Tr. Exh. 1562.) Marshfield recognized that a new HMO competitor, if it could obtain participation of Marshfield's physicians, could immediately undercut Security's prices by twenty percent. (*Id.*)

Compcare, however, failed in its attempts to break Security's hold as the dominant provider of HMO services in north-central Wisconsin. (Pet. App. 27a-28a; *see also* Tr. 71, 102, 112-20, 311-13, 1116-17; Tr. Exh. 44, 1156, 1226, 1229, 1295, 1301, 1883.) When Compcare tried to enlist Marshfield and other physicians or hospitals in the region to provide services to its potential HMO subscribers, it was completely unable to do so. (Pet. App. 27a-28a; *see also* Tr. 597, 599-602, 621.) Marshfield's own 400 physicians were unavailable on reasonable terms. (*Id.*) And Marshfield had taken steps to minimize the effects of potential competition from other physicians by making these physicians "affiliates" of Security.

Marshfield induced independent physicians to affiliate with Security by using a "carrot and stick" approach. First, the affiliation agreements offered by Security are unusually lucrative for the physicians involved. (Pet. App. 36a.) Unlike the usual HMO affiliation agreements in competitive markets, the Security agreements provide that affiliated physicians will be compensated for services provided to Security subscribers *at their usual fee rates*—so long as the affiliated physicians further agree to a "most favored nation" ("MFN") clause preventing them from receiving *less* from any other patient or health plan. (Pet. App. 16a-17a, 36a.) This arrangement creates a huge disincentive for physicians to affiliate with other HMOs seeking to pay, and ultimately to charge, at competitive rates, because physicians who affiliate with such HMOs must give up the higher compensation available from Security.

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its HMO product 15% to 75% above comparable products in the State and Nation. (Tr. 1119-22.)

At the same time, Marshfield made it clear that physicians who refuse to affiliate will face ruinous competition, problems with maintaining staff privileges in the region's hospitals, and problems obtaining cross-coverage of patients from other physicians. (Pet. App. 13a, 28a, 33a.) As noted, Marshfield owns or has partnerships with most of the hospitals in the region, which enables it to eliminate competition with Marshfield and to control the ability of unaffiliated physicians to gain staff privileges in those hospitals. (Pet. App. 31a, 33a; *see also* Tr. 58, 201-16, 483, 713, 925-28.)

The evidence at trial also showed that Security used even more direct methods to prevent HMO or physician competition.[4] Some affiliation agreements even expressly barred other clinics from participating in other HMOs. (Pet. App. 36a-37a, 48a-49a; *see also* Tr. 712-13, 856-57, 865-71, 1361-62.) And when Security faced competition from one smaller HMO (NCHPP) on the edge of its region, it agreed to a geographic division of markets—allowing NCHPP to dominate in the two counties where it was currently based so long as NCHPP did not expand into the neighboring counties (on three sides) where Security was the dominant HMO. (Pet. App. 17a-18a, 48a-49a; *see also* Tr. 856-57, 865-66, 870-71.)[5]

Security is able to make generous financial arrangements with its many affiliate physicians precisely because it is the dominant HMO operating in its region. Not

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[4] Citing "abundant evidence in the record," the district court agreed with the jury that there was "direct evidence that defendants acted with the specific intent to restrict competition." (Pet. App. 33a.) For example, Marshfield openly acknowledged meeting on a regular basis with its neighboring "supposed competitors" to "plan" marketing and physician placement, restrict managed care offerings, limit physician recruitment, limit new services, set prices for services, and reach understandings on future acquisitions. (Pet. App. 36a, 47a-53a.)

[5] The jury's finding of this *per se* violation of Section 1 of the Sherman Act was *affirmed* by the Seventh Circuit. (Pet. App. 17a-19a.)

coincidentally, Security charges subscribers far above the usual competitive prices for HMO services in Wisconsin. (Pet. App. 33a, 36a; *see also* Tr. 1118-22; Tr. Exh. 11, 12, 13.) Indeed, the evidence showed that Security did not provide employers or employees with *any* savings over traditional indemnity insurance plans (*id.*), even though, as the Seventh Circuit acknowledged (Pet. App. 5a), one would ordinarily expect such a price differential because HMOs are not substitutes for traditional health-care plans: HMOs limit patients' choice of physicians and utilization of medical services, and must therefore charge less than traditional plans—everywhere except in Marshfield's territory. Security can charge these extraordinary prices only because Marshfield has effectively excluded other HMOs from the market. In fact, Marshfield's own internal documents acknowledged that if a new HMO entered the market, Security's prices would have to drop by twenty percent—in its own words, Security would no longer be able to "mark-up" prices. (Tr. 985; Tr. Exh. 1562.) Thus, there was every reason to conclude (as did the jury and the district court) that Security is charging a monopoly price and that Marshfield had engaged in actions that were anticompetitive and restraints of trade.

Petitioners brought this action, alleging that respondents had conspired and attempted to monopolize, and succeeded in monopolizing, HMO and physician services in north-central Wisconsin, in violation of Section 2 of the Sherman Act and the parallel Wisconsin antitrust statute. The complaint also alleged that respondents had contracted, combined and conspired with others in restraint of trade.

After a full trial on liability,[6] the jury returned special verdicts finding that plaintiffs had established a relevant market for HMO services, and that defendants were liable under each of the antitrust claims set forth above. (Pet. App. 21a, 74a-76a.) After the damages phase of the

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[6] The district court had earlier denied defendants' motion for summary judgment. 881 F. Supp. 1309 (W.D. Wis. 1994).

trial, the jury awarded Blue Cross $10,500,000 in actual damages and awarded Compcare $5,669,227. (*Id.*)

The district court then (1) denied respondents' motion for judgment as a matter of law in all respects, except with respect to the finding of attempted monopolization; (2) denied respondents' motion for a new trial on liability; (3) denied respondents' motion for a new trial on damages, conditioned upon petitioners' acceptance of a remittitur, and (4) entered an injunction. Petitioners accepted the remittitur, whereupon the district court entered judgment in favor of Compcare in the amount of $15,223,182 (after trebling), and in favor of Blue Cross in the amount of $1,784,649 (after trebling), plus costs and attorneys' fees. The district court's opinion carefully reviewed the trial record, finding there was ample evidence to support nearly all of the jury's findings. (Pet. App. 21a-63a.)

On appeal, respondents challenged the sufficiency of the evidence, but raised no objections to the jury instructions regarding the antitrust laws. The court of appeals affirmed the verdict and judgment as to respondents' liability for geographic market division but reversed the balance of the verdict and remanded for a new trial as to damages and for reformulation of injunctive relief. Although the court acknowledged that the defendants had "a monopoly market share of the HMO 'market' " (Pet. App. 12a), it held that HMOs do not constitute a market under Section 2 because consumers and physicians could consider other forms of medical services to be substitutes for HMOs. (Pet. App. 5a-7a, 10a.) Having failed to find monopoly power in a properly defined market, the court refused to consider evidence that respondents had engaged in a broad pattern of exclusionary practices and had garnered extraordinarily high profits. (Pet. App. 9a, 12a-13a.) As for the Section 1 claim, the court characterized MFN clauses in the affiliation agreements as a mechanism for lowering prices, "the sort of conduct that the antitrust laws seek to *encourage*" (Pet. App. 17a (emphasis added)); but it upheld the jury's

conclusion that Security had geographically divided markets to keep other HMOs out of its "territory." (Pet. App. 17a-19a.)

The court of appeals denied a petition for rehearing, supported by *amici* the United States and the Federal Trade Commission, and at the same time amended its initial slip opinion. (Pet. App. 64a-65a.)

REASONS FOR GRANTING THE WRIT

Petitioners presented compelling evidence that Marshfield and its wholly owned HMO unlawfully monopolized and unreasonably and anticompetitively excluded petitioners from the market for HMO services, thereby injuring petitioners and forcing consumers in north-central Wisconsin to pay substantially inflated prices. Although a properly instructed jury found that evidence persuasive, the Seventh Circuit felt free to overturn the verdicts because they did not square with the court's preconceptions about the laws of economics. Rigorous economic analysis does play an essential role in the application of the antitrust laws, but it is a tool that must be used with care. Economic laws, like laws passed by legislatures, must be applied to the actual facts of a case. A court's facility with economic analysis does not give it license to ignore the evidence (including expert economic testimony) offered at trial and accepted by a jury, in order to create a neat package that fits easily within a preconceived economic model. That is precisely what occurred here.

As this case vividly illustrates, appellate review driven by unyielding adherence to economic models can have harmful repercussions extending far beyond the participants in a particular case. The Seventh Circuit has decreed that, as a matter of economic (and now federal) law, there is no separate market for HMO services. (Pet. App. 3a-13a, 65a.) *This means that nothing done by an HMO to exclude competition from other HMOs can violate the monopolization prohibition in Section 2 of the Sherman Act, or related "Rule of Reason" components of Section 1.* Indeed, the court of appeals went so far

as to hold that the Sherman Act is not implicated even where, as here, a large physician-owned HMO enters into *de facto* exclusive contracts with nearly every physician in the region. (*See* Pet. App. 16a-17a.)

These holdings are a matter of major concern, because they rule out the application of the antitrust laws to prevent the very kinds of anticompetitive activity that economists have identified as a likely outgrowth of the ongoing changes in the structure of the health-care industry. *See, e.g.*, Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs*, 14 Am. J.L. & Med. 147 (1988); Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988). The Seventh Circuit's decision will now protect such conduct: it encourages existing physician groups and their HMOs to consolidate with one another at will and to sign *explicitly* exclusive agreements with other local physicians to keep out potential competitors; and it will stimulate the trend of physicians to create their own exclusive HMOs and limit the choices available to consumers. At a time when private market reform through "managed care" is becoming the wave of the future, it makes no sense to allow the structure of the health-care system to evolve in such anticompetitive directions based on economic theorizing that does not capture the reality of the marketplace. That is why we ask the Court to consider these issues *now*, rather than in some future case.

Remarkably, the Seventh Circuit adhered to its sweeping decision despite full awareness of its potentially broad effects. An *amicus* brief filed by the United States and the FTC in support of rehearing expressed serious concern that, at a time when "[h]ealth care markets are evolving rapidly," the decision might be interpreted as establishing a "rule of general applicability" that HMOs are not a market and that affiliation agreements with MFN clauses are not anticompetitive. Br. Amicus Curiae of the U.S. and FTC, at 4-9 (filed Oct. 2, 1995) (reprinted at Pet.

App. 66a, 68a-72a).[7] But the court's only response, in its order *denying* rehearing, was to make four limited changes in the text of the opinion that did not, by any stretch of the imagination, limit the impact of the case to its facts. (Pet. App. 65a.) This case thus warrants review because it still threatens to produce the very harms the United States and the FTC predicted.

I. THE SEVENTH CIRCUIT'S KEY RULINGS CONSTITUTE BROADLY APPLICABLE GENERALIZATIONS ABOUT THE ECONOMICS OF THE HEALTH-CARE SYSTEM NOT LIMITED TO A PARTICULAR FACTUAL CONTEXT.

The Seventh Circuit's key rulings—that HMOs do not constitute a separate market and that the contractual and other relationships between Marshfield and other health-care providers cannot be viewed as anticompetitive—were based on economic generalizations rather than record evidence. If left undisturbed, these generalizations will have a broad negative impact. This was true when the court of appeals issued its original decision, prompting the United States and the FTC to urge the court to limit the breadth of its holdings. And it is no less true now that the court of appeals has responded with *pro forma* qualifying language without otherwise altering its analysis of economic "realities" in the health-care field.

Turning first to the Seventh Circuit's holding that "HMOs are not a market" (Pet. App. 10a, 65a), there is nothing in the court's analysis to suggest that this conclusion is limited to a particular time, place, or trial record. The court asserted:

> The record shows, what is anyway well known, that individuals, and their employers, and medical insurers (the real "buyers" of medical services, according to the plaintiffs) regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including "preferred

[7] The Government took no position on whether the trial record in this case supported the jury's verdict. (Pet. App. 68a, 72a-73a.)

> provider" plans (generally referred to as "PPOs," for "preferred provider organization") . . . .

(Pet. App. 5a.)[8] Based on this assertion, the court concluded that the "price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from [other] forms of medical-services contracting" and, thus, that HMOs *in general* share a market with traditional health insurance products. (Pet. App. 5a-7a.) One searches these pronouncements in vain for any citation to the trial record, much less a demonstration that this particular record precluded a rational trier of fact from reaching a different conclusion. This general approach thus stands in sharp contrast to the district court's opinion which, based on specific reference to expert testimony, federal law, state law, regulations, employee programs, consumer preferences, history, and all manner of other evidence, concluded that the jury properly found that "an HMO is a distinct and unique form of health care financing for which a relevant product market exists." (Pet. App. 24a.)

The circuit court's conclusion that the contractual arrangements between Marshfield's HMO and the 900 other physicians in the region are not anticompetitive is equally broad in its potential impact. The court simply noted that these contracts with physician competitors do not *expressly* "forbid [the competitors] to join other HMOs or otherwise compete with Security or with the Marshfield Clinic" (Pet. App. 7a),[9] and then relied on the un-

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[8] Unlike HMOs—which are characterized by the use of a gatekeeper, aggressively managed care through risk sharing, and preventive medicine (Pet. App. 24a)—PPOs are simply a form of traditional fee-for-service health insurance under which "the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds." (Pet. App. 5a.)

[9] The U.S. Department of Justice and the FTC "determine whether a physician network venture is exclusive or non-exclusive by its and its members' activities and not simply by the terms of the contractual relationship." DOJ and FTC Statements of Enforcement Policy and Analytical Principles Relating to Health

supported generalization that MFN clauses "are standard devices by which buyers try to bargain for low prices" and thus are "the sort of conduct that the antitrust laws seek to encourage." (Pet. App. 17a.) The court saw no need even to consider whether the contracts might be vehicles for tacit collusion as to price levels or refusals to deal.

Nothing of substance was changed after the Justice Department and the FTC filed their *amicus* brief and the Seventh Circuit made four perfunctory amendments to its opinion. (Pet. App. 65a.) With respect to the HMO market issue, although the court now admits the theoretical possibility that other types of HMOs and PPOs existing elsewhere "may vary in respects crucial to antitrust liability" (*id.*), there is no discussion of the particular features of the Security HMO or traditional health insurance plans available in north-central Wisconsin that could provide a basis for distinguishing this case in the future. The court's reasoning remains entirely generic and universal and entirely ungrounded in the trial record. Similarly, although the court now says that "[p]erhaps . . . [MFN] clauses are misused to anticompetitive ends in some cases" (*id.*), one is left to wonder how, in some future case, the evidence of such misuse could be stronger than it was here, where the court of appeals nevertheless held that no rational jury could have found an anticompetitive effect.

For these reasons, the opinion, fairly read, leaves lower courts in future cases with no basis for distinguishing, or escaping from, the Seventh Circuit's views of the generally applicable laws of economics.

Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788, 20,796-97 (Sept. 29, 1994). The district court cited evidence of the type of contracts involved, expectations about patient referrals (including referrals of non-HMO patients), fee schedule approval, and market allocations to find that the "express" language was a facade. (Pet. App. 31a-33a, 36a-37a.) The court of appeals did not dispute any of this evidence.

II. THE SEVENTH CIRCUIT'S RULINGS ARE WRONG, BOTH AS A GENERAL MATTER AND AS APPLIED TO THIS CASE.

The Seventh Circuit's generalizations about the nature of economic reality, far from being truisms, are dubious as a general matter and flatly incorrect as applied to the facts of this case. There is every reason to conclude that HMO services can constitute a relevant market and that HMO affiliation agreements of the kind at issue here, with express MFN clauses and buttressed by other predatory and conspiratorial conduct, can have the purpose and effect of substantially lessening competition among physicians and among HMOs. Indeed, the evidence presented in this case—evidence the court of appeals largely disregarded—demonstrates that the Seventh Circuit's dogmatic generalizations based on preconceived economic theories do not hold water at all times and in all places. At the very least, that evidence makes it clear that the court of appeals had no basis for second-guessing the jury's resolution of these issues.

1. *The HMO Market Issue.* Market definition in an antitrust case is an intensely fact-based undertaking, requiring consideration of a variety of relevant factors. *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 481-82 (1992); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325-28 (1962). The question whether a particular market exists is ultimately as much a question of consumer perception as of economic modeling. The issue is whether theoretical alternatives are such good substitutes that an attempted price increase above the competitive level would cause enough consumers to switch or enough other suppliers to enter and drive the price back down. An attempted price increase will be profitable if enough consumers perceive such distinct qualities in a product that they will continue to purchase it at the supracompetitive price rather than switching to possible alternatives, and if new providers are unable or unwilling to meet consumer demand at a lower price. (Pet. App. 69a-70a & 70a n.1.) *See United States v.*

Grinnell Corp., 384 U.S. 563, 571-72 (1966). Thus, the mere fact that HMOs face *some* competition from other forms of health-care delivery cannot be dispositive; unless that competition is strong enough to constrain HMOs from raising their prices significantly above competitive levels, there is still a separate product market for HMO services. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993) ("Here, the issue for an economist would be whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits.").

This Court has pointed to a number of "practical indicia" of market definition: "industry or public recognition of the [market] as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." *Brown Shoe*, 370 U.S. at 325; *see U.S. Healthcare*, 986 F.2d at 599 ("[u]sage patterns, customer surveys, actual profit levels, comparison of features, ease of entry, and many other facts are pertinent in" deciding whether there is a separate HMO market).[10]

Viewed from this perspective, it makes sense to treat HMOs and other forms of health-care delivery and financing as separate relevant markets. To begin with, consumers see these "products" as very different. (Pet. App. 23a-24a.) The Seventh Circuit itself emphasized this

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[10] By relying on abstract, neoclassical economic models supposedly subsumed within "contemporary principles of antitrust" (Pet. App. 3a), rather than on *Brown Shoe*'s "practical indicia" for market definition, the Seventh Circuit also contradicted precedents from its sister circuits. *See, e.g., United States Anchor Mfg., Inc. v. Rule Indus., Inc.*, 7 F.3d 986, 995 (11th Cir. 1993) (applying *Brown Shoe*'s "practical indicia"), *cert. denied*, 114 S. Ct. 2710 (1994); *Olin Corp. v. FTC*, 986 F.2d 1295, 1298-99 (9th Cir. 1993) (same), *cert. denied*, 114 S. Ct. 1051 (1994); *Fineman v. Armstrong World Indus., Inc.*, 980 F.2d 171, 199 (3d Cir. 1992) (same), *cert. denied*, 113 S. Ct. 1285 (1993); *H.J., Inc. v. International Tel. & Tel. Corp.*, 867 F.2d 1531, 1540 (8th Cir. 1989) (same).

point: the particular structure of an HMO (*i.e.*, payment of a flat rate for a year's medical care) has "consequences both for the practice of medicine and for the allocation of the risk of medical expenses." (Pet. App. 3a.) "Many people don't like [HMOs] because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service since . . . the marginal revenue of a medical procedure to an HMO is zero." (Pet. App. 5a.) But HMOs have desirable features as well: they guarantee all needed care for a fixed sum (Pet. App. 3a-4a), and they minimize or eliminate paperwork. This distinctive mix of benefits and burdens is appealing to some consumers, even if it is unappealing to others. HMOs also are controlled under entirely separate state and federal regulatory schemes (Pet. App. 23a-24a; Tr. 62, 1111, 2310; Tr. Exh. 4; *see also* 42 U.S.C. § 300e-9; Wis. Stat. § 609.96)—a factor this Court has seen as indicative of a separate market. *See United States v. Connecticut Nat'l Bank*, 418 U.S. 656, 660-66 (1974).

This case illustrates the "practical indicia" that might reasonably lead one to conclude that, in a given region (such as north-central Wisconsin), other forms of health-care financing are not such close substitutes that a sole provider of HMO services would lack the ability to garner monopoly profits. To begin with, although the Seventh Circuit concluded that HMO prices are "constrained" by competition from traditional health insurance plans, Security *itself* admitted that it could charge monopoly prices as long as it was the only *HMO* operating in the region and the only "competition" it faced was other types of health plans. (Tr. Exh. 1562, 1563.) Security's internal documents estimate that its prices were twenty percent higher than it could charge if an HMO competitor entered the market. (*Id.*) Yet, while still charging that higher price, Security maintained a group of 70,000 subscribers who did not opt instead for more traditional insurance.

Moreover, Security's recognition that there is a separate HMO market in the region is confirmed not only by its own pricing strategy but also by the fact that its other exclusionary acts and agreements were aimed at preventing competition *from HMOs*, not from traditional health insurance plans. For example, Security agreed to a geographic market division with another HMO (NCHPP) operating in two nearby counties (Pet. App. 17a-19a, 36a-37a, 48a-49a; *see also* Tr. 856-57, 865-66, 870-71; Tr. Exhs. 1177, 1123, 1481), and it had express agreements with some of its affiliates that they would not work with any other HMO. (Pet. App. 36a-37a, 48a-49a; Tr. 712-13, 856-57, 865-71, 1361-62.)[11] If Security believed it would be forced by competition from PPOs or other forms of insurance to charge a competitive price, there would have been little point in entering into HMO-specific market-division agreements.

Another important market-determining factor is state and federal regulatory laws that preclude other types of health plans from substituting for HMOs. These laws require certain employers to offer their employees a separate HMO option. (Pet. App. 23a-24a.)[12] But Security is the only HMO option in north-central Wisconsin. (Pet. App. 23a.) As a result of these laws, when large em-

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[11] The administrator of Rhinelander Medical Center ("RMC") acknowledged at trial that Marshfield asked the RMC physicians not to participate in NCHPP—another HMO with which Security had divided the market. (Pet. App. 49a; Tr. 712-13.) The RMC physicians then dropped participation in NCHPP. (*Id.*)

[12] HMOs are required to be made available by certain large private employers and by state and local governments whenever feasible. 42 U.S.C. § 300e-9. Similarly, the federal government authorizes Medicare beneficiaries to receive their benefits through HMOs that contract with the Health Care Financing Administration. *Id.* § 1395mm; 42 C.F.R. § 417.420. Wisconsin, in particular, has created a comprehensive legislative package to treat HMOs as a distinct product. Wisconsin law provides that the Wisconsin Department of Health and Social Services may contract with HMOs to provide health benefits to beneficiaries of medical assistance, Wis. Stat. § 49.45(9), and creates distinct HMO capital and other requirements, *id.* § 609.96.

ployers are selecting health plans to offer to their employees, there is *no* competition between Security and traditional health insurance plans. Security can extract a monopoly profit without fear that employers will not offer Security's plan.[13]

The court of appeals also opines that the absence of barriers to entry precludes treating HMO services as a separate market. (Pet. App. 6a-7a.) But this reasoning begs the question, because barriers to entry are what this case is all about.[14] Petitioners, after all, attempted to create a competing HMO in the region, but were unable to do so because of exclusionary conduct by Marshfield and Security and its affiliated physicians. (Pet. App. 27a-28a.) An "HMO must be able to line up enough physicians with whom to contract to provide its subscribers with a more or less complete menu of medical services." (Pet. App. 4a.)[15] In this sense, the question of market definition in this case is closely linked with the second major issue on which the Seventh Circuit overruled the

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[13] There may still be some price competition between Security and traditional insurance when *employees* are selecting among plans that are offered. But that will only be true where employers require employees to pay part of the cost of their health coverage *and* these employee contributions are tied directly to the price paid by the employer.

[14] These are not barriers based only on economic theory. Rather, they are barriers created by real-life monopolistic and conspiratorial conduct by Marshfield and Security. (*See* Pet. App. 27a-28a, 31a-33a.)

[15] For this reason, the Seventh Circuit's discussion of PPOs is entirely incorrect. Because HMO enrollees are *required* to seek care from an HMO doctor, the HMO *must* have a complete array of providers. Without a complete array, the HMO could not be sold—as the court recognized. (Pet. App. 4a.) The patient in a PPO, by contrast, is free to go to any doctor. If, for example, his insurer's PPO lacks a nearby eye doctor, he can go to a non-PPO physician instead and still be covered by his insurance. The Seventh Circuit's reasoning that, because Blue Cross had a small PPO in part of the area, it could also establish a competing HMO (Pet. App. 6a) is a *non sequitur* because a PPO does not require a comprehensive array of providers, whereas an HMO does.

factfinder—*i.e.*, whether the affiliation agreements effectively blocked access to Security's affiliated physicians by a competing HMO. See pages 18-21 below.

The Seventh Circuit did not bother with any of these facts. It simply looked at the issue of market definition at an abstract level, and concluded that HMOs always face enough competition or potential competition to preclude viewing them as a separate market. Because of these preconceptions, it saw no need to take into account the actual evidence in the record that led a rational jury to conclude that HMO services, at least in north-central Wisconsin, do constitute a separate market.[16] That ruling effectively strips factfinders—whether judge or jury—of the discretion they must have if the antitrust laws are to retain sufficient flexibility to respond to complex and changing market conditions.

2. *The Issue of the Affiliation Agreements and Related Actions Aimed at Precluding HMO Access to Independent Physicians.* The situation is much the same with respect to the Seventh Circuit's holding that the Security affiliation agreements are not anticompetitive. Here again, the record considered by the jury contained ample evidence that the affiliation agreements function like exclusive contracts, establishing artificial price floors and making the affiliates effectively unavailable to other HMO entrants. (Pet. App. 36a-37a.) Moreover, that record demonstrated that Marshfield used other tactics, such as denial of staff privileges, refusal to cross cover, and selective acquisition of clinics in order to threaten or eliminate

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[16] *Compare* Louis Kaplow, *The Accuracy of Traditional Market Power Analysis and a Direct Adjustment Alternative*, 95 Harv. L. Rev. 1817, 1827 (1982) (criticizing then-Professor Posner's approach to market definition because "it forces an all-or-nothing framework on an issue that is in fact a question of degree"); *see also id.* at 1818 ("Combining markets to deal with problems of market definition [as Professor Posner recommends] . . . generally will lead one to understate market power, and the degree of understatement in many contexts will be substantial.")

competitors (*see* Pet. App. 13a, 31a-33a)—all designed to keep physicians within the Marshfield fold.

Yet the Seventh Circuit dismissed concerns about the agreements themselves based on its view that MFN clauses are always pro-competitive. (Pet. App. 16a-17a.) And, almost as an aside, it expressed skepticism that Marshfield's other actions toward independent physicians are "exclusionary in an invidious sense." (Pet. App. 13a.) It did so based on the conclusion that such practices are "ambiguous from the standpoint of competition and efficiency." (*Id.*)

This will not do. First, regardless of how MFN clauses may operate in other contexts, there was ample evidence that the affiliation agreements here had the purpose and effect of barring competition. Marshfield pays physicians signing up with its Security Health Plan at a rate well above what is paid by any conventional HMO and then recoups that amount from consumers by charging rates well above those charged by HMOs elsewhere in Wisconsin.[17] The use of MFN clauses within those agreements is essential to maintain anticompetitive pricing because it means that such affiliated physicians cannot sign up with another HMO at the discounted price usually paid by an HMO without simultaneously forfeiting the benefits of the Security full-fee payments. In substance, Marshfield through Security gave the affiliates a share of its monopoly profits, conditioned on the affiliate not giving any competing HMO a better deal. Moreover, the agreements were shown to amount to tacit acceptance of the affiliates into the Marshfield family, which produced the collateral benefit of avoiding direct competition from Marshfield, while maintaining cooperative relationships with other area physicians and hospitals. (*See* Pet. App. 31a-33a.) *See also* 6 Phillip E. Areeda, *Antitrust Law*

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[17] At trial, it was *undisputed* that Security's prices far exceeded those charged by other Wisconsin HMOs and exceeded the highest comparable state and federal HMO programs by 15% to 75%. (Tr. 1119-22.)

§ 1435e, at 229-31 (1986) (an MFN clause may be an unreasonable restraint of trade under Section 1 when it "facilitate[s] tacit price coordination" and "restrain[s] the seller's freedom of action in other transactions").

The Seventh Circuit had no basis for disregarding these facts. Indeed, commentators have also noted the anticompetitive effects of MFN clauses in comparable circumstances, as well as the potential for tacit collusion through the vehicle of an HMO. *See, e.g.*, Baker, *supra*, at 167-68 ("The most favored nations clause may have deterred cheating on a physician cartel, thereby facilitating collusion among doctors, by making it uneconomic for physicians to lower their fees to those patients participating in the HMO."); Miller, *supra*, at 235 ("In the long run, managed care vertical restraints imposed by dominant insurers and designed primarily to exclude prepaid plan competitors—rather than to produce more efficient service—could injure competition in both health services and health insurance markets."). The Seventh Circuit's approach disdained all of these not-so-subtle market realities, and generically endorsed MFN clauses without even a hint about the circumstances that might render them anticompetitive. (Pet. App. 17a ("standard devices").)[18]

This almost cavalier approach is even more amazing in light of the evidence that truly independent physicians were punished by Marshfield. (Pet. App. 31a, 33a, 50a-52a.) The Seventh Circuit did not dispute that evidence.

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[18] In referring to Judge Posner's "Chicago School" philosophy in a different case, one respected commentator noted: "[W]hen a court dismisses an antitrust complaint about a vertical restraint by saying that 'restricted dealing is a way to compete,' . . . it has substituted rhetoric for argument. Those are very well chosen words. They are both conclusive and expansive—but they prove nothing in themselves and are not a description of exhaustive empirical work verifying an hypothesis; in fact, they are nothing more than an expression of one opinion about the competitive effects of vertical restraints." Herbert Hovenkamp, *Rhetoric and Skepticism in Antitrust Argument*, 84 Mich. L. Rev. 1721, 1721-22 (1986) (footnote omitted).

(*See* Pet. App. 13a.) Yet it failed even to consider it in evaluating the effects of the affiliation agreements themselves. (Pet. App. 16a-17a.) And it went on to say that the jury was wrong to attribute significance to this conduct because its anticompetitive nature was "ambiguous." (Pet. App. 13a.)

If there was "ambiguity," of course, it was up to the finder of fact to weigh all of the circumstances and determine whether the conduct was anticompetitive. That is what the jury did here. And the proper model for judicial review of such a determination is the opinion of the district court, which reviewed all of the evidence and gave appropriate deference to the finder of fact. The Seventh Circuit's standard is a clear departure from that mandated approach.

In sum, this case illustrates the wisdom of the admonition, in the Government's *amicus* brief filed in the court below, that courts should "avoid any temptation to substitute reliance on generalizations or assumptions about the functioning of health care markets for careful analysis of the evidence presented in a particular case." (Pet. App. 69a.) The Seventh Circuit's "generalizations or assumptions" cannot be squared with the actual circumstances presented in this case. They should not be left in place as judicially endorsed rules of (economic) law that will bind lower courts in future disputes.

More generally, this decision typifies the dangers of an all-too-common tendency (especially among appellate judges) to espouse *rules* of *non*liability intended to minimize "false positives" (*i.e.*, legal prohibitions of conduct that is not anticompetitive)—even at the risk of repeated "false negatives" (*i.e.*, immunity from antitrust liability for anticompetitive conduct). *See* Frank H. Easterbrook, *Workable Antitrust Policy*, 84 Mich. L. Rev. 1696, 1701, 1706 (1986).[19]

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[19] This attitude is often associated with the "Chicago School" of antitrust analysis. *See* Lawrence A. Sullivan, *Post-Chicago Economics: Economists, Lawyers, Judges, and Enforcement Officials*

This Court has recently admonished against "per se rules of nonliability" based purely on "theoretical and legal arguments": "when the realities of the market and the record facts" indicate that anticompetitive effects have occurred, "theory will not stand in the way of liability." *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2591 (1993) (citing *Kodak*, *supra*). Recent scholarship by leaders of the "Post-Chicago School" of antitrust analysis has confirmed that careful factual investigation may provide "anticompetitive explanations for behavior regarded by Chicago scholars as unambiguously efficient."[20] *See Kodak*, 504 U.S. at 473-79 (citing and applying the work of leading Post-Chicagoans). Of particular relevance to the present case, these critiques have convincingly challenged (1) overly simplistic methods of defining markets and measuring market power;[21] (2) the thesis that competition is never harmed by exclusive dealing arrangements;[22] and (3) the

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in a Less Determinate Theoretical World, 63 Antitrust L.J. 669, 670 (1995) ("Chicago analysts who focus on antitrust tend both to start and stop with deductive analysis based on a sequence of truisms expressed through highly abstracted models of reality.").

[20] Michael S. Jacobs, *An Essay on the Normative Foundations of Antitrust Economics*, 74 N.C. L. Rev. 219, 241 (1995). *See generally Symposium on Post-Chicago Economics*, 63 Antitrust L.J. 445-695 (1995); Ian Ayres, *Playing Games with the Law*, 42 Stan. L. Rev. 1291 (1990).

[21] *Compare* William A. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937 (1981) *with* Kaplow, *supra* (criticizing Landes and Posner's approach to market definition) *and* Jonathan B. Baker & Timothy F. Bresnahan, *Empirical Methods of Identifying and Measuring Market Power*, 61 Antitrust L.J. 3 (1992) (advocating new econometric techniques for the direct measurement of market power).

[22] *Compare* Richard A. Posner, *Antitrust Law: An Economic Perspective* 203-04 (1976) *and* Robert H. Bork, *The Antitrust Paradox: A Policy at War with Itself* 138-42, 262, 304, 309 (2d ed. 1993) *with* Joseph F. Brodley & Ching-to Albert Ma, *Contract Penalties, Monopolizing Strategies, and Antitrust Policy*, 45 Stan. L. Rev. 1161, 1163 (1993) *and* Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 Yale L.J. 209 (1986).

notion that MFN clauses that raise potential rivals' costs cannot constitute barriers to entry.[23]

The Seventh Circuit's ruling in this case is a paradigmatic example of the attitudes and approaches that have come under severe criticism in the scholarship of the Post-Chicagoans. But the Sherman Act no more embodies the Chicago School's version of neoclassical price theory than the Fourteenth Amendment "enact[s] Mr. Herbert Spencer's Social Statics." *Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting).

III. THESE RULINGS WARRANT REVIEW BECAUSE OF THEIR POTENTIAL IMPACT ON THE FUTURE SHAPE OF THE HEALTH-CARE SYSTEM.

The Court should seize the opportunity to review the issues raised here *now*. To begin with, because the Seventh Circuit spoke in such broadly applicable terms, and because there is a full trial record, this case presents a clean and appropriate vehicle for clarifying how antitrust principles should apply in this context. Moreover, such clarification is vitally important *today* because there is an ongoing shift toward HMOs and other forms of managed care that will soon be accelerated by federal legislation. If the decision below is allowed to stand, HMOs such as Security not only will profit enormously at the expense of medical consumers, but they also will be allowed permanently to consolidate their monopolies over HMO services at a time when the HMO sector is poised to become the dominant force in American health care.

Enrollment in HMOs has soared from 2 million in 1970 to 20 million in 1985 and more than 51 million today.[24] HMO enrollment will accelerate further in the

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[23] *Compare* Easterbrook, *Workable Antitrust Policy*, *supra*, at 1710 *with* Baker, *supra and* Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. Rev. 863 (1991).

[24] Steven Findlay, *Will Big HMOs Stamp Out Competition?*, Business & Health, Oct. 1995, at 52; Sheldon Greenfield et al., *Outcomes of Patients with Hypertension and Non-insulin-dependent*

late 1990s, as private market competition increases and the government continues to embrace HMOs as a new method for delivering publicly funded medical care. At least 46 states have enacted legislation directed at HMOs. Jon B. Christianson et al., *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991). And both the federal and state governments have turned increasingly to HMOs as a potentially efficient method of health-care delivery in Medicare, Medicaid, and employee programs.

Indeed, while the debates over health-care reform in 1994 and the balanced budget in 1995 and early 1996 have often been divisive, at least one point of consensus has crystallized: managed care, including HMOs, will play an increasingly central role in American health care for the remainder of this decade and on into the next century. Last summer, Congress enacted legislation to expand "Medicare Select"—which encourages senior citizens to join managed-care programs—from a fifteen-State experiment to a fifty-State permanent program. *See* Pub. L. No. 104-18 (1995). Moreover, the expanded use of HMOs by Medicare and Medicaid alike is central to the seven-year balanced-budget legislation that is currently being debated. For example, both the congressionally approved version of the balanced-budget bill and its Administration counterpart provide Medicare beneficiaries a variety of new options including coverage through HMOs and health plans organized by doctors and hospitals. *See* H.R. Rep. No. 350, 104th Cong., 1st Sess. (1995) (conference report to accompany H.R. 2491, the Balanced Budget Act of 1995, which was passed by the House and Senate in November 1995 and vetoed by the President on December 6, 1995); Health Provisions of President Clinton's Seven-Year Budget Plan, Health Care Pol'y Rep. (BNA Dec. 11, 1995).

Diabetes Mellitus Treated by Different Systems and Specialties: Results From the Medical Outcomes Study, 274 J. Am. Med. Ass'n 1436, 1436 (1995).

The bipartisan consensus favoring HMOs is founded on two assumptions. First, as an empirical matter, competition by managed-care organizations has reduced—and can continue to reduce—health-care costs throughout the Nation.[25] The fact that HMOs have *not* served this cost-containing function in north-central Wisconsin clearly highlights the risks of allowing any single HMO to obtain monopoly power within a geographic market.

Second, it is assumed that antitrust laws will continue to apply to the health-care industry with full vigor and effect. In the twenty years since this Court established in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), that professionals are subject to the same rules governing competitive behavior that apply to other businesses, *id.* at 786-88, federal antitrust law has played a critical role in eliminating barriers to competition among health-care providers and insurers. "Removal of these barriers effectively created an atmosphere in which innovative payment systems could flourish and providers could freely accept alternative practice and compensation agreements."[26] In the mid-1990s, those competing innovations and alternatives are receiving the imprimatur of Congress and the executive branch. If HMOs and other physician-owned networks are allowed to monopolize services in particular geographic markets just as the federal government grants them a privileged place in health-care policy, the damage will be serious, and may be irreversible. It has long been recognized that the accoutrements of monopoly include not only extraordinarily high profits,

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[25] *See* Congressional Budget Office, The Effects of Managed Care and Managed Competition (Aug. 22, 1995) (largely attributing 1994's relatively low rate of medical inflation to the increased use of managed care); U.S. General Accounting Office, Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs, GAO/HEHS-96-2 (Oct. 4, 1995); KPMG Peat Marwick LLP, Health Plans in 1995 (Sept. 1995) (HMO costs increased by only 0.4% in 1994, while medical inflation averaged 4.6% per year).

[26] Thomas L. Greaney, *When Politics and Law Collide: Why Health Care Reform Does Not Need Antitrust "Reform"*, 39 St. Louis L.J. 135, 137 (1994).

but also the ability to bar entry into the market by potential rivals. As Judge Learned Hand explained a half century ago, "immunity from competition is a narcotic, and rivalry is a stimulant, to industrial progress." *United States v. Aluminium Co. of America*, 148 F.2d 416, 427 (2d Cir. 1945). It makes no sense to insulate HMOs from antitrust scrutiny and thereby to allow monopolistic HMOs to consolidate their market power at the very moment when Congress is recognizing competition among HMOs as the primary stimulant to progress in the health-care industry.

This is particularly true in light of the fact that *physician-owned* HMOs (such as Security), which currently constitute only fifteen percent of all HMOs, are now the fastest growing sector within the HMO market.[27] The new Medicare provisions of the balanced-budget bill expressly preempt state regulatory systems that currently prevent physicians and hospitals from participating in the HMO market unless they meet that State's HMO insurance requirements.[28] As a result, in the next two years, tens of millions of Medicare beneficiaries may, for the first time, be able to choose physician-owned HMOs.[29]

In this context, the decision below presents two particularly disturbing problems. First, a serious consequence of the Seventh Circuit's refusal to recognize that HMOs can constitute a relevant product market is that no amount of consolidation of HMOs in a given region could violate

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[27] Mark D. Whitener, Deputy Director, Health Care Division, FTC, *Antitrust, Medicare Reform and Health Care Competition*, 1995 WL 714346 (F.T.C.), at *6 (remarks before the American Enterprise Institute) (Dec. 5, 1995).

[28] The preemption provision was added in order to gain the support of physicians' and hospitals' groups for the balanced-budget bill. *See* Robert A. Rosenblatt, *Doctors Prescribe Medicare HMOs as Panacea for Ailing Bottom Lines*, L.A. Times, Nov. 25, 1995, at A29.

[29] *See* Rosenblatt, *supra* note 28.

federal antitrust law.[20] This fear is not merely academic. In the last eight years, notwithstanding the remarkable rate of growth in demand for HMO services, the number of HMOs nationwide has *decreased* by more than fifteen percent. As one industry publication recently put it, HMOs have been "struck with bigness fever": 1994 witnessed thirteen HMO mergers and acquisitions, worth $4.0 billion, and the pace of HMO mergers picked up in 1995. Findlay, *Will Big HMOs Stamp Out Competition?*, *supra*, at 52. Not surprisingly, this concentration often comes at consumers' expense. *See* Douglas R. Wholey et al., *The Effect of Market Structure on HMO Premiums*, 14 J. Health Econ. 81, 101 (1995) ("The strongest conclusion from our research is that a larger number of HMOs in a market area is related to lower HMO premiums."). In Massachusetts, for example, where recent mergers have enabled three HMOs to capture roughly two-thirds of the HMO market—one of the highest levels of concentration in the country (outside of north-central Wisconsin)—HMO premiums run 20% to 25% above the national average. *See* Dan Wise, *Massachusetts: High Prices in a Managed Care Stronghold*, Business & Health, Oct. 1995, at 37.[21]

The Seventh Circuit did not stop, of course, with the HMO market. It then went on to hold that Security's

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[20] *Compare* Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks Before the Group Health Ass'n of Am. (Feb. 28, 1989) (HMO controlling more than 35% of available providers and precluding them directly or indirectly through MFN clauses would pose antitrust problems).

[21] "[W]here there is not a competitive HMO system, prices are higher and access is limited. In northern Wisconsin, there is virtually one HMO and its rates have been documented as being well in excess of the state average. This area also has the highest uninsured rate in the state." *The Transformation of the Medicaid Program: Hearings Before the Subcomm. on Health and Environment of the House Comm. on Commerce*, 104th Cong., 1st Sess. (1995) (statement of Rep. Scott Klug); *see also supra* note 3. The uninsured rate in northern Wisconsin is 44% higher than the rest of the State. Wis. Dep't of Health and Social Servs., Ctr. for Health Stats., Report on the Uninsured and Insured, table 3 (1995).

absence of market power prevented the court from even considering *vertical* restraints that may violate the Sherman Act. (*See* Pet. App. 12a-13a.) Its decision would require courts to turn a blind eye toward business practices that would become commonplace if this decision stands. In particular, HMOs would have carte blanche (1) to raise the costs of rival HMOs by securing MFN agreements from "affiliated" physicians, (2) to refuse to allow participating physicians to "cross-cover" for non-affiliated physicians, (3) to prevent hospitals they control from joining other HMOs, and (4) to discriminatorily obstruct staff privileges at those hospitals.

These problems are compounded when physicians own HMOs, as physicians own Marshfield and Security. (Pet. App. 2a-3a.) This horizontal component increases the risk that arrangements with HMOs will do more to suppress competition among physicians than to increase consumer choice. *Compare Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982).

The importance of this case to the application of antitrust principles in health care was demonstrated, in part, by the scope of the *amicus* participation in the Seventh Circuit—reflecting both major physician associations (*e.g.*, the American Medical Association, the Medical Group Management Association, the American Group Practice Association, and the State Medical Society of Wisconsin) and representatives of national health insurers (*e.g.*, the Health Insurance Association of America and the Blue Cross Association). The legal, medical, and general press throughout the country has recognized that the issues squarely presented by *this case* represent the most important antitrust concerns in health care.[32] Be-

[32] Coverage and commentary on this case has included: Bradley G. Clary & Michel A. LaFond, *Antitrust and Integrated Delivery Systems*, Health L. Dig., Feb. 1995, at 3; *Wisconsin Antitrust Verdict Rattles Insurers and HMOs*, Bus. & Health, Feb. 1995, at 57; *Wisconsin Clinic Disputes Antitrust Ruling*, Mod. Healthcare, Apr. 3, 1995, at 6; *Blue Cross Prevails on Monopolization, § 1 Charges Against Marshfield Clinic, HMO*, Antitrust & Trade Reg.

cause prompt resolution of those issues is of vital importance to the ongoing national health-care debate, the Court should grant review of the petition.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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Rep. (BNA) No. 1707, at 443 (Apr. 6, 1995); *Wisconsin Blues Seek Second Verdict, This Time in the People's Court*, Mod. Healthcare, May 15, 1995, at 52; *Lack of HMO Market is Fatal Weakness, Marshfield Clinic Says in Appeals Brief*, Health L. Rep. (BNA) No. 4, at 1212 (Aug. 10, 1995); Thomas Campbell, *Market for HMO Services, Definition at Issue in Marshfield Appeal*, 2 Health Care Antitrust Man. No. 7, at 1 (Sept. 1995); *Blue Cross' Damages in Case Against Marshfield Clinic's HMO Must Be Retried*, Antitrust & Trade Reg. Rep. (BNA) No. 1730, at 331 (Sept. 21, 1995); *Rural Wisconsin Medical Clinic and Its HMO Did Not Monopolize*, Trade Reg. Rep. (CCH) No. 387, at 1 (Sept. 27, 1995); Mary Chris Jaklevic, *Feds Challenge Marshfield Ruling*, Mod. Healthcare, Oct. 9, 1995, at 33.

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees, Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellees. Cross-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin
No. 94 C 137 S—JOHN C. SHABAZ, *Judge*

ARGUED AUGUST 9, 1995—DECIDED SEPTEMBER 18, 1995

Before POSNER, *Chief Judge,* and BAUER and KANNE, *Circuit Judges.*

POSNER, *Chief Judge.* Blue Cross & Blue Shield United of Wisconsin ("Blue Cross" for short), and its subsidiary, Compcare Health Services Insurance Corporation, a health maintenance organization (HMO), brought suit last year

under sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2 against the Marshfield Clinic and its HMO subsidiary, Security Health Plan of Wisconsin, Inc. After a two-week trial, the jury brought in a verdict for both plaintiffs that, after remittitur, trebling, and addition of attorneys' fees, produced a judgment just short of $20 million to which the judge then added a sweeping injunction that we have stayed pending the decision of the defendants' appeal, which we have heard on an expedited schedule. (The plaintiffs filed a cross-appeal, but it was dismissed by agreement of the parties.) The speed with which this complex case was brought to trial is as commendable as it is unusual.

The two plaintiffs have distinct though overlapping claims. Compcare, Blue Cross's HMO, claims that the Marshfield Clinic—a nonprofit corporation owned by the 400 physicians whom it employs—has a monopoly which it acquired and has maintained by improper practices that have excluded Compcare from the HMO "market" in the counties of north central Wisconsin in which the Marshfield Clinic and its HMO subsidiary (Security) operate. This is a section 2 monopolization charge. Blue Cross claims that Marshfield, partly through its own monopoly power and partly by collusion with other providers of medical services, charged supracompetitive prices to patients insured by Blue Cross. This is a section 2 monopolization charge combined with a section 1 price-fixing and division-of-markets charge.

Although Marshfield is a town of only 20,000 people in a largely rural region, the Marshfield Clinic is the fifth largest physician-owned clinic in North America, with annual revenues in excess of $200 million. The Clinic has its main office in Marshfield but it has 21 branch offices scattered throughout the 14 counties of north central Wisconsin. Oddly, we cannot find in the record, nor were counsel able to inform us at argument, what percentage the 400 physicians employed by the Clinic comprise of all

the physicians in the 14 counties. We do know that the Clinic employs all the physicians in Marshfield itself and in several other towns—but one of these towns has only one physician—and all the physicians in one entire county—but a county that has only 12 physicians. Security, the Marshfield Clinic's HMO subsidiary, serves its subscribers through the physicians employed by the Clinic plus almost 900 other physicians with whom Security has contracts. These contracts are not exclusive—the physicians are free to work for other HMOs as well as to practice fee-for-service medicine—and in fact work for Security generates only 6 percent of these physicians' total income. In nine of the 14 counties in the north central region, Security has more than 90 percent of all subscribers to HMOs.

Compcare persuaded the jury that HMOs constitute a separate market, much as banks are a separate market from currency exchanges; and if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we might think as an original matter. But we have searched the record in vain for evidence that under contemporary principles of antitrust law would justify such a finding. An HMO is not a distinctive organizational form or assemblage of skills, as is plain from the fact that the physicians retained by Security, whether they are employees of the Marshfield Clinic or completely independent, to serve its subscribers serve other patients on a fee-for-service basis. An HMO is basically a method of pricing medical services. Instead of having the patient pay separately for each medical procedure, the patient pays a fixed annual fee for all the services he needs and the HMO undertakes to provide those services with the physicians with whom it has contracts. The different method of pricing used by the HMO has, of course, consequences both for the practice of medicine and for the allocation of the risk of medical expenses. The method of pricing gives the HMO an incentive to minimize the procedures that it performs, since the marginal

revenue it derives from each procedure is zero. Hence HMOs are thought to reduce "waste" and to encourage preventive care, although those hostile to the HMO concept believe that the principal effect is merely to reduce the amount of medical care that patients receive. The risk-shifting feature of the concept lies in the fact that if a subscriber incurs above-average medical expenses, the excess cost is borne by the HMO rather than by the subscriber (or by his insurer, or more likely by both because of copayment and deductible provisions in the insurance policy), while if he incurs below-average medical expense the difference enures to the benefit of the HMO rather than to him or his insurer (or, again, both). To control the upside risk that it incurs, the HMO provides medical services through physicians with whom it has contracts specifying their compensation, rather than merely reimbursing some percentage of whatever fee they might happen to charge for their services. This means that the HMO must be able to line up enough physicians with whom to contract to provide its subscribers with a more or less complete menu of medical services. Compcare complains that Security's contracts with physicians require them to refer their patients to the Clinic rather than to "independent" physicians. But that is of the essence of an HMO: the subscriber must take the service offered by the physicians whom the HMO has enlisted.

Compcare's principal argument is that Security has enlisted such a large fraction of the physicians in the 14-county north central region that Compcare cannot find enough "independent" physicians to be able to offer HMO services competitive with Security's—hence Security's huge market shares in 9 of the 14 counties. Supposing this is true—as seems unlikely since Security's almost 900 independent physicians are available to join other HMOs, along with an unknown number of physicians neither employed by the Marshfield Clinic nor retained by Security—it has monopolistic significance only if HMOs constitute a market separate from other contractual forms in which

many of the same physicians sell their services. Of this we cannot find any evidence.

In defining a market, one must consider substitution both by buyers and by sellers, IIA Phillip E. Areeda, John L. Solow & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 530a (1995), and let us start with buyers. The record shows, what is anyway well known, that individuals, and their employers, and medical insurers (the real "buyers" of medical services, according to the plaintiffs) regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including "preferred provider" plans (generally referred to as "PPOs," for "preferred provider organization") under which the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds. HMOs, though they have made great strides in recent years because of the widespread concern with skyrocketing medical costs, remain relative upstarts in the market for physician services. Many people don't like them because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service since, as we said, the marginal revenue of a medical procedure to an HMO is zero. From a short-term financial standpoint—which we do not suggest is the only standpoint that an HMO is likely to have—the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible. HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service plans.

We do not wish to associate ourselves with the critics of HMOs. All that is important to our consideration of this appeal is that many people believe—whether rightly or wrongly is of no moment—that HMOs are not an unalloyed blessing; and this means that the price that an

HMO can charge is constrained not only by competition from other HMOs but also by competition from forms of medical-services contracting that are free from the perceived perverse incentive effects of the HMO form. As far as we know or the record shows, even in areas where there is only one HMO most of the people in its service area do not subscribe to it even if its prices are lower than those of fee-for-service providers.

We do not understand Compcare to be contending that insurance companies cannot find enough physicians in the north central region willing to sign contracts with them to staff preferred-provider plans. This has a dual significance. Such plans are particularly close substitutes for HMOs, since they use the insurer's clout with physicians to drive down price. And if, as the record shows, they are feasible even in areas supposedly dominated by the Marshfield Clinic, and even without including any physicians employed by the Clinic, it is impossible to understand what barrier there could be to the formation of HMOs. All that is needed is an array of physicians who among them provide a broad range of medical services, and the same thing is needed for a preferred-provider plan. Ability to create a preferred-provider plan therefore implies ability to create an HMO, and so implies in turn that if Security raised its prices above competitive levels, and if people had a strong preference for HMOs over preferred-provider plans despite the similarities between the two systems for providing medical care, the operators of those plans would convert them to HMOs. If so, those plans are part of the same market with HMOs. So Blue Cross and Blue Shield of Indiana argued in *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986), and we accepted its argument. *Id.* at 1331-37.

As we said earlier, the definition of a market depends on substitutability on the supply side as well as on the demand side. Even if two products are completely differ-

ent from the consumer's standpoint, if they are made by the same producers an increase in the price of one that is not cost-justified will induce producers to shift production from the other product to this one in order to increase their profits by selling at a supracompetitive price. *SBC Communications Inc. v. FCC*, 56 F.3d 1484, 1493-94 (D.C. Cir. 1995); cf. *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra*, 784 F.2d at 1335. The services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others.

We thus do not believe that a reasonable jury, confronting the record compiled in the district court, could find that HMOs constitute a separate market. Nor, if we examine a more plausible market such as all physician services in north central Wisconsin and thus shift our focus from Compcare, the HMO, to the Marshfield Clinic itself, is there any basis in the record for treating the Clinic not as the alliance of 400 physicians that is the Marshfield Clinic but instead as the almost 1300 physicians who are either employed by the Clinic or have contracts with Security. The 900 independent contractors derive only a small fraction of their income from those contracts, as we have seen, and the contracts do not forbid them to join other HMOs or otherwise compete with Security or with the Marshfield Clinic.

It is true that because of the sparsity of the physician population in north central Wisconsin the physicians employed by the Clinic have a large share of the market for physician services, since, for primary care anyway (an important qualification—people will go a long way for a liver transplant), that market is a local one. Remember, there is one entire county in which all the physicians are employed by the Clinic. We do not understand Compcare to be arguing that *this* is the market that the Clinic monopolized; the damages to Compcare from being

excluded (if it was excluded—we do not know) from that tiny market would be tiny. Compcare paints with a broader brush, drawing a dizzying series of concentric circles around the Clinic's offices and counting the physicians who can serve people living in the circles. It would have been much simpler and we suppose just as good—having in mind the desirability of avoiding a hunt for the snark of delusive exactness—to have treated the counties as the markets. But whatever the precise method chosen, Compcare is unable to show that in what it chooses to regard as the relevant geographic market or series of linked geographic markets for physician services the Marshfield Clinic employed 50 percent or more of the physicians serving the market. And 50 percent is below any accepted benchmark for inferring monopoly power from market share, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990); *Fineman v. Armstrong World Industries, Inc.*, 980 F.2d 171, 201-02 (3d Cir. 1992); *Colorado Interstate Gas Co. v. Natural Gas Pipeline Co.*, 885 F.2d 683, 694 n. 18 (10th Cir. 1989); *United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir. 1945) (L. Hand, J.), and the Clinic has given us no reason for lowering the mark. Compcare is able to derive larger shares only by defining submarkets of specific, very narrowly defined medical procedures, called "Diagnostic Related Groups," such as circumcision of a male 17 years old or older, circumcision of a male under 17, hysterectomy, and reconstructive surgery for the uterine system, in a few of which (14 out of 494, according to Compcare's expert witness) the physicians employed by or under contract with Marshfield Clinic performed most of the procedures in north central Wisconsin. As the examples we have given show, classification in a DRG is unrelated to the conditions of supply. Many, no doubt most, physicians perform or are capable of performing more than one procedure, and are therefore part of the market even if at present not active in it. If the Clinic overprices a particular procedure, other phy-

sicians capable of performing that procedure will have an added incentive to do so, knocking down the excessive price.

Compcare also asked the jury to infer monopoly power directly from the Clinic's high prices, and high rate of return, relative to the prices and rates of return of its competitors. But when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices—the difference may reflect a higher quality more costly to provide—and it is always treacherous to try to infer monopoly power from a high rate of return. Taking the second point first, not only do measured rates of return reflect accounting conventions more than they do real profits (or losses), as an economist would understand these terms, Susan Rose-Ackerman, "Unfair Competition and Corporate Income Taxation, 34 *Stan. L. Rev.* 1017, 1025 n. 28, 1031 n. 43 (1982); Michael Boudin, "Forensic Economics," 97 *Harv. L. Rev.* 835, 837 (1984), but there is not even a good economic theory that associates monopoly power with a high rate of return. Firms compete to become and to remain monopolists, and the process of competition erodes their profits. Conversely, competitive firms may be highly profitable merely by virtue of having low costs as a result of superior efficiency, yet not sufficiently lower costs than all other competitors to enable the firm to take over its market and become a monopolist. As for high prices, one of the complaints against HMOs, remember, is that they skimp on service. One HMO may charge higher prices than other HMOs (and Security does charge higher prices) not because it has a monopoly but because it is offering better service than the other HMOs in its market. Compcare itself stresses the quality of the Marshfield Clinic's doctors, as part of its argument that it cannot succeed unless the Clinic is forced to join it. Generally you must pay more for higher quality.

So Security is not a monopolist of HMO services, because HMOs are not a market; and the Marshfield Clinic, its parent, is not a monopolist either because it does not control its independent contractors and once they are excluded, the Clinic (which is to say the physicians who own and are employed by it—who are the firm, functionally speaking) does not have a monopoly of physician services in the north central region or in any parts of the region other than parts too small to support more than a handful of physicians. If the Marshfield Clinic is a monopolist in any of these areas it is what is called a "natural monopolist," which is to say a firm that has no competitors simply because the market is too small to support more than a single firm. If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice modern medicine in rural Wisconsin.

We are mindful that a concept of essential or bottleneck facilities has been used from time to time to require a natural monopolist to cooperate with would-be competitors. E.g., *Otter Tail Power Co. v. United States,* 410 U.S. 366 (1973); *MCI Communications Corp. v. AT&T Corp.,* 708 F.2d 1081, 1132-33 (7th Cir. 1983). The principal case remains the old St. Louis terminal case. *United States v. Terminal Railroad Ass'n,* 224 U.S. 383 (1912). A consortium of 14 of the 24 railroads that shipped freight across the Mississippi River at St. Louis got control of the terminal facilities at each side of the river. The Supreme Court, while assuming that the operation of these facilities as a single entity was the most efficient way to operate them (that is, they comprised a

natural monopoly), held that the Sherman Act required the consortium to provide access to the terminal facilities to the 10 other railroads on nondiscriminatory terms. The decision, along with the rest of the decisions in the essential-facilities line, has been criticized as having nothing to do with the purposes of antitrust law. E.g., Herbert Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 7.7 (1994); Phillip Areeda, "Essential Facilities: An Epithet in Need of Limiting Principles," 58 *Antitrust L.J.* 841 (1990); Scott D. Makar, "The Essential Facilities Doctrine and the Health Care Industry," 21 *Fla. St. U.L. Rev.* 913 (1994). Had the terminal facilities been owned by a firm unaffiliated with any railroad, the firm could have charged whatever prices it wanted, including prices that discriminated against some of the users (monopolists frequently price discriminate), because the antitrust laws do not regulate the prices of natural monopolists. A natural monopolist that acquired and maintained its monopoly without excluding competitors by improper means is not guilty of "monopolizing" in violation of the Sherman Act, *National Reporting Co. v. Alderson Reporting Co.*, 763 F.2d 1020, 1023-24 (8th Cir. 1985); *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430, and can therefore charge any price that it wants, *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra,* 784 F.2d at 1339; *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 296-98 (2d Cir. 1979), for the antitrust laws are not a price-control statute or a public-utility or common-carrier rate-regulation statute.

And the charging of a high price is, so far as potential competitors are concerned, an attracting rather than an excluding practice. Consumers are not better off if the natural monopolist is forced to share some of his profits with potential competitors, as required by *Terminal Railroad Ass'n.* Similarly, if the practice of medicine in some sparsely populated county of north central Wisconsin is a natural monopoly, consumers will not be helped by our

forcing the handful of physicians there to affiliate with multiple HMOs. Those physicians will still charge fees reflecting their monopoly.

We are not authorized to abrogate doctrines that have been endorsed and not yet rejected by the Supreme Court —as we acknowledged, indeed emphasized, with specific reference to the "essential facilities" doctrine, in *Olympia Equipment Leasing Co. v. Western Union Telegraph Co.*, 797 F.2d 370, 376 (7th Cir. 1986)—but we do not understand Compcare to be trying to pin the tail on the natural-monopoly donkey. Its argument is not that the Marshfield Clinic "owns" some tiny natural monopolies scattered throughout its market area, to which it must admit Compcare, but that the Clinic itself is an essential facility that any HMO may demand access to on equal terms, like the excluded railroads in the terminal case. To be an essential facility, however, a facility must be essential. The terminal association controlled 100 percent of a market, assumed to be properly defined, consisting of terminal services at St. Louis. The Clinic does not control 100 percent—or even 50 percent—of any properly defined market. It did have a monopoly market share of the HMO "market," but we have held that that is not a proper market; and likewise the DRGs. Nor can the Clinic's market share be levered up to 100 percent by the argument that the Clinic's reputation is so superb that no one will sign up with an HMO or preferred-provider plan that does not have the Clinic on its roster. The suggestion that the price of being "best" is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect. "The successful competitor, having been urged to compete, must not be turned upon when he wins." *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430.

Since monopoly power was not proved, we need not evaluate the practices by which the Clinic acquired or

maintained it. But we will not conceal our skepticism that they are exclusionary in an invidious sense. Compcare argues that the Clinic refused to allow its employees to "cross-cover" with "independent" physicians, in the sense of physicians not employed by or affiliated by contract with the Clinic (that is, agree to care for another physician's patients when that physician is on vacation or otherwise unavailable in exchange for a reciprocal agreement by the other physician), discouraged hospitals that its staff controlled from joining HMOs that compete with Security, and restricted staff privileges at those hospitals of "independent" physicians. All these practices are ambiguous from the standpoint of competition and efficiency. Hospitals are not public utilities, required to grant staff privileges to anyone with a medical license. The Marshfield Clinic's reputation for high quality implies selectivity in the granting of staff privileges at hospitals affiliated with the Clinic. Physicians employed by the Clinic, which has its own HMO, are hardly to be expected to steer their patients to another HMO, as they would be doing if they used their control of hospital staffs to induce the hospital to join another HMO. And given the extensive network constituted by the physicians either employed by or contracting with the Clinic, they would have little occasion to "cross-cover" with other physicians and would be reluctant to do so if, as is completely consistent with Compcare's version of the "essential facilities" doctrine, the Clinic maintains a reputation for high quality by being selective about the physicians to whom it entrusts its customers. But the important point is that, even if these practices are as we doubt tortious interferences with Compcare's business, they do not constitute monopolizing in violation of section 2 of the Sherman Act in the absence of acceptable proof, here lacking, of monopoly power.

We turn to Blue Cross's case. Blue Cross claims that it was overcharged by the Clinic. Many of the individuals whom Blue Cross insures in north central Wisconsin are

customers of the Marshfield Clinic, paying for the services they receive from the Clinic on a fee-for-service basis. (The Clinic's doctors devote only a small part of their time to Security's HMO clientele.) Blue Cross pays the Clinic directly the portion of the fee that Blue Cross has agreed with its insureds to cover. The Clinic seeks to head off Blue Cross's claim at the pass, arguing that since the Clinic's fee-for-service contracts are with the patients themselves—it has no contract with Blue Cross—only the patients have "standing" (a term here not used in the jurisdictional sense, *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 535 n. 31 (1983)) to complain about the alleged overcharging.

If the patients paid the entire fees to the Clinic and then were reimbursed in whole or part by Blue Cross, the Clinic would be right: only the patients could sue. The Supreme Court has been emphatic that only the direct purchaser from an allegedly overcharging defendant has standing to maintain an antitrust suit. *Kansas v. Utilicorp United Inc.*, 497 U.S. 199 (1990); *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977). But here the money went directly from Blue Cross to the Clinic, and although the two entities were not linked by any overarching contract, each payment and acceptance was a separate completed contract. We do not think more is required to establish Blue Cross's right to sue to collect these overcharges. *Pennsylvania Dental Ass'n v. Medical Service Ass'n*, 815 F.2d 270, 276-77 (3d Cir. 1987); *Todorov v. DCH Healthcare Authority*, 921 F.2d 1438, 1455 (11th Cir. 1991); cf. *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 926 (1st Cir. 1984). It would be cumbersome, to say the least, for patients of the Marshfield Clinic to organize into a class action to recover money that the patients never paid and that if they received in a judgment or settlement they would have to share with Blue Cross; for Blue Cross could seek and probably obtain restitution of moneys paid by mistake to the insureds

because paid for expenses that the insureds had not in the end incurred. 2 George E. Palmer, *The Law of Restitution* § 11.2(d), p. 491 (1978); *Home Ins. Co. v. Honaker*, 480 A.2d 652 (Del. 1984); *Ticor Title Ins. Co. v. Graham*, 576 N.E.2d 1332, 1336-37 (Ind. App. 1991).

Against this it can be argued that if Blue Cross reimburses an insured for say 80 percent of a $100 charge that should have been only $50, Blue Cross has lost $40 but the insured has lost $10 and so there is still a basis for a class action. Still, in this example anyway it is Blue Cross that bears the lion's share of the loss, as well as being able to proceed on its own without the aggregation of separate plaintiffs required for a class action; and the class action would enable a full recovery of the damages inflicted by the defendant only if the class members received a tremendous windfall—only, that is, if the class is allowed to recover $40 rather than $10 (and the entire $50 will of course be trebled). It can further be argued that the insured might pay the whole $50, because Blue Cross would reduce the percentage that it reimburses in order to shift the cost of the monopolist's overcharge to the hapless insureds. But the insureds may not be hapless—may in fact be members of the employees' group insurance plan of a large employer with plenty of insurance options. We need not pursue these issues. Blue Cross paid Marshfield Clinic directly, in accordance with Blue Cross's contractual obligations to its insureds, and if it paid too much because the Clinic violated the antitrust laws then it ought to be allowed to sue to recover these damages.

We note a tension between Blue Cross's claim and Compcare's. Blue Cross claims that the Clinic overcharged. The higher its prices, the greater the opening for competitors, such as Compcare. Even if Compcare could not get a foot-hold in the HMO "market," it could, of course, provide medical services through other means,

such as a preferred-provider plan; and the higher the prices charged by the Marshfield Clinic, the more attractive such a plan offered by Compcare would be to employers and other purchasers of medical plans. To put the point differently, Blue Cross has a dual role in this case, as a buyer of medical services from Marshfield Clinic and, through its Compcare subsidiary, as a competitor of the Clinic. As a competitor its interest is in the Clinic's charging high prices, but as a buyer its interest is in the Clinic's charging low prices. Damages to Compcare are windfalls to Blue Cross, and vice versa. The damages awarded by the jury to the two plaintiffs (since they are economically one entity) should have been netted against each other rather than aggregated.

But that is a detail, since Compcare, for the reasons discussed earlier, was not entitled to recover any damages at all. Forget Compcare, then, and think of Blue Cross solely as a purchaser of medical services. Insofar as it paid high prices because the Marshfield Clinic was a monopolist, its claim must fail because the Clinic was not shown to be an illegal monopolist; a lawful monopolist can charge what it wants. But Blue Cross also claims that the Clinic colluded with competitors to raise prices above competitive levels. That claim is independent of the Clinic's being a monopolist.

Two forms of collusion are charged, with various furbelows and arabasques that can be ignored. The first is collusion between the Clinic and its affiliated (as distinct from employed) physicians. Here the tension between the two plaintiffs' cases again comes to the surface, since it will be recalled that Compcare in its case treats the affiliated physicians as a part of the Clinic, and a firm cannot collude with itself. Forget all that; the only evidence of collusion is that the Clinic, when buying services from the affiliated physicians either directly or through Security, would not pay them more than what these physicians charge their other patients. This is said

to set a floor underneath these physicians' prices, since if they cut prices to their other patients their reimbursement from the Clinic will decline automatically. This is an ingenious but perverse argument. "Most favored nations" clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage. It is not price-fixing. *Brook Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2589-90 (1993); *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1392 (7th Cir. 1986); *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra*, 784 F.2d at 1338.

The other form of collusion alleged is more troublesome. The Clinic is said to have agreed with some of its competitors, in particular the North Central Health Protection Plan, an HMO that had 37,000 subscribers, to divide markets, a practice that violates section 1 of the Sherman Act. *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46 (1990) (per curiam). The analogy between price-fixing and division of markets is compelling. It would be a strange interpretation of antitrust law that forbade competitors to agree on what price to charge, thus eliminating price competition among them, but allowed them to divide markets, thus eliminating all competition among them.

The charge of a division of markets in this case is backed up by some pretty strong documents. In one of them an executive of the Marshfield Clinic, after noting that "at the time in which management of Marshfield Clinic and North Central Health Protection Plan established the Free Flow arrangements, the parties involved purposely chose not to place in writing clear descriptions of their respective Plan service areas so as to minimize any risk in terms of violation of antitrust laws," remarks

that some years ago physicians affiliated with the NCHPP "wished to establish a practice in Marshfield and we took the position that the Free Flow agreement did not support that activity"—and they backed off. The implications of this only slightly Aesopian wording are backed up by statistics showing that Security had fewer than 30 percent of the HMO subscribers in the two counties in which NCHPP was active, while in the counties surrounding those two counties on three sides it had more than 90 percent of the HMO subscribers.

We think the evidence of a division of markets, though a little scanty, was sufficient to sustain the jury's verdict on this (and only this) aspect of the case—provided this is not one of those cases in which a division of markets or other cartel-like activity is actually essential to the provision of a lawful service. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85 (1984); *General Leaseways, Inc. v. National Truck Leasing Ass'n*, 744 F.2d 588 (7th Cir. 1984). The "Free Flow" agreement to which the document from which we quoted refers was an agreement whereby Security's physicians and NCHPP's physicians could refer patients to each other without getting the permission of their superiors. The plan of the physician who rendered the service would bill the other plan for its cost. This was no doubt a valuable service, expanding the range of physicians to whom people enrolled in these two HMOs could turn. But the Clinic has failed to explain why, to provide this service, it was necessary for the two plans to agree not to open offices in each other's territories. We can imagine an argument that would run as follows: if NCHPP, say, opened an office in Marshfield, the doctors staffing that office would constantly be referring patients to the Clinic because it has such a plethora of doctors in Marshfield (remember that it employs *all* the doctors working in that town). The office would be running a referral business, "free riding" on the reputation and

quality of Marshfield's doctors, and perhaps it would be difficult to devise a reimbursement plan under which these doctors would be compensated for these services. It is not a bad argument, but it is not made by the Clinic and it has no support in the record.

We conclude that the jury verdict on liability must stand insofar as the charge of a division of markets is concerned, and therefore the provisions of the injunction (IV(A)(3), (B)(3), (C)(3), (D)(3), and (E)(2), and V(D)(1)—and possibly others; but for the sake of clarity and completeness the injunction ought to be rewritten from scratch in light of our invalidating most of it) that forbid the Clinic to divide markets with competing plans or groups. The rest of the injunction falls with the charges that we have held to be without legal or factual basis. No part of the award of damages or of costs and attorneys' fees can stand, because these items were not segregated by offense. There must be a new trial limited to damages for dividing markets. The burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from that illegal practice.

We have not discussed every contention of the parties, but have said enough to indicate the basis for our decision. As a detail, we urge the bench and bar of this circuit not to imitate the special verdict on liability that went to the jury in this case. The verdict form contained 18 questions. If the jury wanted to find for the plaintiff on every contested point, all it had to do (and all it did do) was write "yes" 18 times. A verdict so configured, like a plea colloquy in which the answer that the defendant is expected to give to every one of the judge's questions is "yes" *Castillo v. United States*, 34 F.3d 443, 445 (7th Cir. 1994), invites rote answers rather than the careful consideration of the structure of the plaintiff's case that the use of a special verdict is intended to foster. Cf. *W.T. Rogers Co. v. Keene*, 778 F.2d 334, 346 (7th Cir. 1985). None of the purposes ascribed to the giving of a special

verdict, *Stewart & Stevenson Services, Inc. v. Pickard,* 749 F.2d 635, 644 (11th Cir. 1984); 9A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2508 (1995), of which probably the most important is to minimize the likelihood or scope of a retrial in a case in which there is more than one independent ground for recovery, are served by a verdict form that does not invite the jurors to use their heads. Given the broad discretion of the trial judge in the formulation of special verdicts, e.g., *Hibma v. Odegaard,* 769 F.2d 1147, 1157 (7th Cir. 1985), and the fact that no objection was made to the form employed here, we do not suggest that this form would have constituted reversible error if the point had been argued; we merely offer for what it is worth our belief that it is not the best possible form, because it does not force the jurors to think before filling it out.

The judgment is affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. Costs on appeal to the appellants.

AFFIRMED IN PART,
REVERSED IN PART, AND REMANDED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-137-S

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Plaintiffs,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Defendants.

MEMORANDUM

Plaintiffs Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") and Compcare Health Service Insurance Corporation ("Compcare") commenced an antitrust action against defendants Marshfield Clinic ("Marshfield") and Security Health Plan of Wisconsin, Inc. ("Security") for money damages, injunctive and declaratory relief. The case was tried to a jury which found for plaintiffs on each question of the Special Verdict finding that (1) plaintiffs established one or more primary care, pediatric care, specialty care and HMO services relevant product and geographical markets and (2) monopoly power therein, (3) defendants engaged in anti-competitive conduct to obtain monopoly power, (4) defendants attempted and (5) conspired to obtain monopoly power, (6) defendants entered into a contract, combination, or conspiracy to unreasonably restrain trade, and (7) defendants allocated customers, territories, product or service markets and fixed fees or prices. The jury found damages in the amount of $10.5 million in favor of Blue Cross and $5,669,227 in favor of Compcare against the defendants. The Court trebled the damages and entered judgment. The action is before this Court on defendants' motion for judgment as

a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure and/or a new trial pursuant to Rule 59 on both the liability and damage verdicts and on plaintiffs' motion for injunctive and declaratory relief.

RULE 50 MOTION

When addressing defendants' motion for judgment as a matter of law the Court must determine whether the evidence presented combined with all reasonable inferences that may be drawn from it, is sufficient to support the verdict when viewed in the light most favorable to the party winning the verdict. Any conflicts in the evidence must be resolved in favor of the party winning the verdict, and every permissible inference favoring that party must be drawn. *Tennes v. Massachusetts Dept. of Revenue,* 944 F.2d 372, 377 (7th Cir.1991).

The Court does not evaluate the credibility of witnesses, nor otherwise weigh the evidence nor consider the numerous post trial affidavits submitted by the parties and those other evidentiary responses which plaintiffs oppose in objecting to defendants' motion for leave to file a sur-reply. Further, when entering its order concerning defendants' motion for judgment as a matter of law or new trial the Court does not consider the numerous petitions, letters, editorials, articles and communications addressed to it which may be better suited for consideration by a legislative body or member thereof. Had both sides expended their energies before trial as they did after trial they might have received a satisfactory verdict. As determined on the Friday before trial, all evidence shall be presented at trial. Once concluded and a verdict entered no further evidence will be considered. The Court's examination of the trial record and motions relating thereto is the basis for its decisions on the motions it will now address.

The jury had sufficient evidence including the testimony of plaintiffs' expert Warren Greenberg to find that plaintiffs had established one or more of the following relevant product and geographical markets: primary care, pediatric

care and one or more specialty care markets. Greenberg specifically defined 13 product markets concerning primary care, pediatrics, specialty care and their geographical limitations. The jury could have readily determined that in nine relevant product and geographical markets Marshfield had a market share in excess of 60% for three years 1991 to 1993. His testimony was supplemented with statistical and economic tests according to Elzinger Hogarty. Although he had not studied a separate HMO economic market for trial or in his prior work, having failed to conclude that there is an HMO services market separate from other forms of health care financing—such as PPOs, POS and regular indemnity insurance, the jury could have also determined that he did not reject the probability thereof.

There is a further legally sufficient evidentiary basis for a reasonable jury to find that plaintiffs established a relevant product and geographical market in HMO services. The Court acknowledges the importance of finding an HMO market. Without an HMO market, plaintiff Compcare's claim for exclusion from the market cannot stand. Plaintiff's late attempts to argue an alternative basis for liability are to no avail.

The jury had before it the testimony of Michael E. Bernstein from which it could reasonably find from the experiences which he brought that there is a specific HMO Market. (Tr. at 83.) He cited federal law for qualified HMOs which employers are required to provide where they have more than 25 employees and that HMOs compete with one another for such considerations.

Vicki Thoreson, sales director for Blue Cross/Blue Shield for the North Central region testified she sold products other than HMOs and that Security HMO does not compete with these products. From her testimony the jury could find that plaintiffs' PPO plan is a totally different type product than the Security HMO and that customers perceive a fee for service plan as different from an HMO which has different pricing and characteristics.

Jeffrey J. Nohl, president of Compcare which sells HMO products, specifically described those features from

which the jury could reasonably find that an HMO is other than traditional indemnity insurance. Nohl stressed the managed care aspects of an HMO as a separate product. Based upon his ten years of experience in the HMO market he testified as an expert that an HMO is not a financial mechanism as is indemnity insurance. He referred also to separate federal and state laws and regulations relating to the HMO as well as those regulations which separate surplus and capital. The State of Wisconsin has a program for state employees which provides HMO health care for which HMOs may compete. Although Nohl admittedly is not that expert who commands a fee in excess of $400,000.00, nevertheless he testified to three distinct characteristics.

The jury was advised of three distinct characteristics to include, first, the gate keeper where a patient chooses a primary care doctor. The second feature provides for controls on use, monitored care a with capitation agreement and the third provides for preventive care and wellness programs where the quality of care is chosen as a part of HMO membership. Michael L. Glassman, the defendants' expert opined that an HMO market did not exist but rather a health care financing market existed of which the HMO is a part. He did not believe the Wisconsin program which requires or mandates separate HMOs to state employees and Medicaid recipients was relevant nor was the separate capital structure for companies who are able to sell HMOs. He had not considered the separate regulations and laws relating to the HMO believing them not to have made a difference in his opinion. From all of this the jury could have reasonably determined that an HMO is a distinct and unique form of health care financing for which a relevant product market exists.

Some limited interchangeability exists in the health care financing market particularly between HMOs and PPOs and between HMOs and indemnity insurance when a monopoly raises the cost of HMOs. Richard A. Posner in *Antitrust Law, An Economic Perspective,* 127-128

(1976) explained how monopoly prices can make poor substitutes appear interchangeable to the consumer. "In the leading case of *United States v. E.I. du Point de Nemours & Co.* (the cellophane monopolization case), the Supreme Court stated that the 'market is composed of products that have reasonable interchangeability for the purposes for which they are produced-price, use and qualities considered.' " *Id.* at 127. The cellophane formulation is deficient in that it

> fails to specify the price level at which the products alleged to comprise the relevant market are reasonably interchangeable. . . . At a high enough price even poor substitutes look good to the consumer. . . . In *du Pont* the issue was whether the defendants had monopoly power, and in that setting it was vital to specify whether cellophane and other flexible wrapping material were reasonably interchangeable at the *current* price of cellophane which might be a monopoly price, or at the *competitive* price (i.e., cost) of cellophane. Reasonable interchangeability at the current price but not at a competitive price level, far form demonstrating absence of monopoly power, might well be a symptom of that power; this elementary point was completely overlooked by the Court.

Id. at 127-128. Thus, HMOs may be interchangeable with indemnity insurance when they are priced at monopolistic levels, as is Security HMO, but are considerably less expensive than indemnity insurance, and correspondingly less substitutable, in competitive markets. Considering this and the consumer's convenience and preference, the jury had legally sufficient evidence upon which it could find that the consumer expects to receive a unique and distinctive service from an HMO not either envisioned or provided by indemnity insurance, all at a lower cost.

Finally, Nohl testified to a geographical market which was described as a 20 to 30 minute drive time around

those primary care doctors who are "the key since each person is to select one and all care is channeled through that primary care doctor. With that selection you have a relationship with the primary care doctor. A 20 to 30 minute drive around is basically the area that an HMO can operate."

The Court is well aware of the defendants' position relating to the HMO Market and has examined among others the following cases: *Ball Memorial Hosp., Inc. v. Mutual Hosp. Insurance Inc.*, 784 F.2d 1325, 1334-1336 (7th Cir. 1986); *Tunis Brothers Co., v. Ford Motor Co.*, 952 F.2d 715 (3d Cir. 1991); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993) as well as *Morgenstern v. Wilson*, 29 F.3d 1291 (8th Cir. 1994).

The Court then concludes that this is not the case referred to in *Morgenstern* described as "when an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, or when indisputable record facts contradict or otherwise render the opinion unreasonable, it cannot support a jury's verdict." *Id.* at 1297

Here there was not that evidence that the HMO services failed to occupy a relevant product and geographical market, only the argument from Glassman that plaintiffs had not provided enough such evidence and that he had not considered those criteria which were utilized.

The Court further notes that the plaintiffs' expert witness on damages, John Beyer, testified that Compcare was foreclosed from the core areas of Marshfield Clinic's service area from selling Compcare HMO Products and his opinion considering HMOs as a separate market is stated as follows: "If you mean by separate market defining it as a separate relevant product market in an antitrust setting as we heard in the prior phase of this trial, the answer is no." (Tr. at 2583.) His testimony specifically related however to two distinct primary markets. The Greater Marshfield Health Plan which operates in the counties of Wood, Jackson, Clark, western part of

Marathon, Taylor, Rusk and to a certain extent Sawyer and the Northcare Plan in the counties of Oneida, Vilas, Iron, Ashland and part of Lincoln where Security has 100% enrollment in five of the above counties. (Exhibit 934, attached)

Similarly, plaintiff Compcare's essential facility claim is supported by the evidence. A monopolist's refusal to deal is governed by the "essential facilities doctrine." *MCI Communications Co. v. AT&T Co.*, 708 F.2d 1081, 1132 (7th Cir. 1983).

> "Such a refusal may be unlawful because a monopolist's control of an essential facility can extend monopoly power from one stage of production to another, and from one market into another. Thus, the antitrust laws have imposed on firms controlling an essential facility the obligation to make the facility available on non-discriminatory terms.
>
> The case law sets forth four elements necessary to establish liability under the essential facilities doctrine: (1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the essential facility; (3) the denial of the use of the facility to a competitor; and (4) the feasibility of providing the facility.

Id. at 1132-1133. To be essential, a " 'facility need not be indispensable; it is sufficient if duplication of the facility would be economically infeasible and if denial of its use inflicts a severe handicap on potential market entrants.' " *Fishman v. Estate of Wirtz*, 807 F.2d 520, 539 (7th Cir. 1986) (citations omitted.), *accord, MCI*, 708 F.2d at 1148.

Defendants challenge Compcare's essential facility claim by stating that the Marshfield doctors are not an essential facility because Nohl testified that POS plans are in the HMO product market and plaintiffs have established a POS plan in areas surrounding Marshfield. That plaintiff established a small POS plan in surrounding

areas does not change the fact that the jury could reasonably find that Compcare could not establish a competing HMO in Marshfield. Moreover, there was evidence that Blue Cross could not duplicate the network of doctors. It was difficult to recruit rural doctors. (Tr. at 540.) Obtaining new doctors or contracting with existing doctors was handicapped by Marshfield's monopolistic tactics, (Tr. at 480), and Marshfield's control of hospital privileges. (Tr. 358-363, 399-401.) Defendants' business justifications for refusing to deal with plaintiffs are refuted by evidence of Marshfield's blanket policy of not entering contracts with other HMOs. (Exhibit 1426.) It was for the jury to decide if Marshfield offered its facility on reasonable grounds. A reasonable jury could have found it was feasible for Marshfield to offer its doctors to Compcare to form an HMO because Marshfield made physicians available to Security and NCHPP, (Tr. at 983-984), and other clinics have contracts with multiple HMOs. (Tr. at 1770.)

Plaintiffs also provided sufficient evidence from which a reasonable jury could have found that plaintiffs suffered antitrust injury. Defendants claim that Blue Cross did not prove it suffered antitrust injury because Blue Cross did not produce evidence that it paid a supra-competitive price, rather Blue Cross only presented evidence that it paid higher than average prices. Defendants claim that higher than average prices are not necessarily the same as supra-competitive prices because of factors like quality and investment. Defendants, however, are wrong. There was sufficient evidence from which a reasonable jury could find Blue Cross paid a supra-competitive price. Blue Cross paid charges to Marshfield that were 10% above the UCR. (Tr. at 127.) In a market basket study, the City of Marshfield's charges were the highest of 23 cities in the state. (Tr. at 160-170.) This was sufficient for the jury to infer the charges were supra-competitive. Antitrust injury may be proved by inference or circumstantial evidence. *Zenith Radio Co. v. Hazeltine Research, Inc.*, 395 U.S. 100, 125 (1969). Moreover supra-competitive prices

are prices that are higher than those Blue Cross would have paid in the absence of defendants' anti-competitive conduct and plaintiffs produced this type of evidence.

Similarly, Blue Cross has standing as a purchaser of physician services. This issue has been resolved in this Court's Order Denying Defendants' Motion for Summary Judgment.

Plaintiffs also produced sufficient evidence defining the other relevant markets. The relevant market must be ascertained in order to determine whether other sellers exist whose competition may limit defendants' monopoly power. *United States v. Grinnell Co.*, 384 U.S. 563, 571 (1966) A relevant geographic market is "the set of sellers to which a set of buyers can turn for supplies at existing or slightly higher prices." *A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.*, 881 F.2d 1396, 1403 (7th Cir. 1989). In a case involving health care, the relevant market must reflect actual patient and physician practices. *SmithKline Co. v. Eli Lilly & Co.*, 427 F. Supp. 1089, 1117-18 (E.D. Pa. 1976), *aff'd*, 575 F.2d 1056 (3rd Cir. 1978), *cert. denied*, 439 U.S. 838 (1978). Delineation of the relevant market is for the trier of fact. *Fishman v. Wirtz*, 807 F.2d 520, 531 (7th Cir. 1986).

Defendants first challenge the sufficiency of the geographic definition of the market for specialty care, claiming that the geographic market for specialty care includes Minnesota and plaintiffs' expert, Greenberg, erred in leaving it out. Defendants cite to *Morgenstern v. Wilson*, 29 F.3d 1291 (8th Cir. 1994) for support. Greenberg did consider Minnesota, (Tr. at 813), but did not include it in the market. He explained that certain communities on the edge of a market can be in two relevant markets. (Tr. at 815.) The jury was entitled to accept this explanation. Plaintiffs distinguish *Morgenstern*, which found the jury's definition of the relevant market to be in error because it left out a city only 50 miles from the defendants' location, because Minnesota providers are close to the state border, but far from Marshfield. Duluth, the Twin Cities, and

Rochester are 217, 166-200 & 160 miles away from Marshfield.

Second, defendants challenge the geographic definition of the primary and pediatric care markets because they overlap and allegedly ignore competing sellers. Plaintiffs' expert, Greenberg, considered the relevant factors: the area defendants targeted, (Tr. at 734), used economic and statistical tests including Elzinger-Hogarty, (Tr. at 737), and economic literature which indicates a 30 mile radius for primary care. (Tr. at 737.) Greenberg explained to the jury how markets can overlap.(Tr. at 804-805.) The jury was entitled to embrace his opinion.

Third, defendants challenge the product market for specialty care asserting that there is no evidence that services in DRGs are good substitutes. Defendants claim that DRGs are merely hospital fee codes. A relevant product market is composed of products or services that are reasonably interchangeable for the purpose for which they are produced. *du Pont,* 351 U.S. at 404. DRGs are a system developed by health economists and used by the federal and state governments and insurance carriers. (Tr. at 730-731.) A jury could reasonably rely on this evidence.

Plaintiffs also provided sufficient evidence from which the jury could find that defendants possessed monopoly power. In some cases, a firm's share of the relevant market indicates market power because market share may reflect a firm's ability to reduce the total output in the market and so raise prices. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins.,* 784 F.2d 1325, 1336 (7th Cir. 1986). Part of proving market power is proving barriers to entry. Unless barriers to entry prevent rivals from entering the market at the same cost of production, even a very large market share does not establish market power. *Will v. Comprehensive Accounting Co.,* 776 F.2d 665, 672 (7th Cir. 1985). The lower the barriers to entry, and the shorter the lags of new entry, the less power existing firms have to raise prices. When the supply is highly

elastic, existing market share does not signify power. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986).

Defendants have not challenged the existence of monopoly power for HMO services.[1] Defendants do, however, challenge the jury's finding of monopoly power in other relevant markets. Defendants assert that no barriers to entry existed because a study demonstrated actual entry of new non-Marshfield doctors into the area. The jury could reasonably have disregarded this evidence because the study counted Marshfield-affiliated doctors as independent doctors, not as Marshfield doctors. (Tr. at 2165.) The study was also statistically flawed. (Tr. at 2291, 2293-2296.) There was ample evidence from which a reasonable jury could have found barriers to entry. It is customary in rural practice to provide cross-coverage. (Tr. at 553, 588.) Marshfield denied cross-coverage to competitors. (Tr. at 501, 526, 463, 353, 397, 480.) Without cross-coverage a doctor must hire temporary doctors known as *locum tenens*. (Tr. at 515-516, 2243-2244, 2267.) This is a significant cost that Marshfield does not incur and is not incurred in other parts of the state. Marshfield also denied and restricted the hospital staff privileges of competitors. (Tr. at 358-363, 399-407.) Lastly, plaintiffs' expert, Greenberg, testified that there were barriers to entry.

Defendants also challenge the inclusion of Marshfield affiliated doctors within defendants' percentage of the market share. Plaintiffs presented sufficient evidence that would justify a jury adding the number of affiliated doctors to defendants' market share. The affiliation contracts are renewable or may be terminated on an annual basis. (Ex. 1444.) The Clinic expects the affiliates to refer non-

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[1] The Court notes that defendants' market share in the primary care market in some areas exceeds defendants' market share in the HMO services market. However, this issue is resolved by the damages award because plaintiffs' expert, Dr. Beyer, calculated Compcare's exclusion damages only in those areas in which defendants had market power for HMOs, smaller areas than the primary care markets.

Security patients to Marshfield, (Tr. at 1030, 1721), and they do, (Tr. at 1030), in a greater volume than non-Security patients. (Ex. 1454, 1841, 1704.) Plaintiffs also presented evidence that price competition between the affiliates and Marshfield is controlled by Marshfield. Marshfield obtains the fee schedules of its affiliates and approves or disapproves them. (Tr. at 1021, 1023.) Marshfield has also allocated markets and territory with affiliated providers, Rhinelander Medical Center and Wausau Medical Center. (Tr. at 865-868, 870-871.) Lastly, plaintiffs' expert testified as to why affiliated providers are included in defendants' market share. (Tr. at 750-752.)

Similarly there was sufficient evidence from which a reasonable jury could find that defendants engaged in anti-competitive conduct. Anti-competitive conduct is defined as the willful acquisition or maintenance of monopoly power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident. *Aspen Skiing Co. v. Aspen Highlands Skiing Co.*, 472 U.S. 585, 596, n.19 (1984); *Olympia Equip. Leasing v. Western Union Telegraph*, 797 F.2d 370, 373 (7th Cir. 1986). In this context willful means conduct designed to maintain or enhance monopoly power improperly. *Olympia*, 797 F.2d at 373. A monopoly like any other competitor, "is permitted and indeed encouraged to compete aggressively on the merits." *Id.* at 375. Improper conduct is conduct characterized as "exclusionary", "anti-competitive" or "predatory". *Aspen Skiing Co. v. Aspen Highlands Skiing Co.*, 472 U.S. 585, 602. In determining whether conduct is exclusionary "it is relevant to consider its impact on consumers and whether it has impaired competition in an unnecessarily restrictive way." *Id.* at 605. If a firm has been "attempting to exclude rivals on some basis other than efficiency," it is fair to characterize its behavior as predatory. *Id.* It is also relevant to consider its impact on antitrust defendants and rivals. *Id.* "Thus, 'exclusionary' comprehends at the most behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does

not further competition on the merits or does so in an unnecessarily restrictive way." *Id.* at 605, n.32.

Defendants assert that there was no evidence of anti-competitive conduct because all defendants' actions have a legitimate business justification and lack anti-competitive intent. There is abundant evidence in the record from which a reasonable jury could find anti-competitive conduct. In the face of direct evidence that defendants acted with the specific intent to restrict competition, the jury was entitled to disregard defendants' alternative explanations. For example, clinics were acquired to threaten competitors. (Tr. at 531-533.) Security affiliation was used to threaten doctors and to force compliance with referral policies. (Tr. at 445-447.) Defendants warned potential new entrants that cross-coverage would be denied because they were competitors, (Tr. at 489), and hospital privileges were denied to competitors. (Tr. 360-363.) These actions excluded competitors from the market and resulted in supra-competitive prices for physician services and HMOs.

Plaintiffs' claim for attempted monopolization, however, must fail. First defendants allege that plaintiffs did not produce any evidence of intentional predatory conduct or dangerous probability of success. These challenges are meritless. However, defendants argue that the Special Verdict was inconsistent because Question 4 asked whether defendants attempted to monopolize in any relevant market in which they do *not* possess monopoly power. Defendants claim that given this finding there can be no finding of antitrust injury because the Court defined antitrust injury as paying supra-competitive prices and exclusion from competition and the definition of monopoly power is the power to control price or exclude competition. According to defendants, by definition defendants must possess market power in order to cause plaintiffs' antitrust injury.

The Special Verdict does contain an inconsistency. The jury found all the relevant markets to exist in Ques-

tion 1. In Question 2 the jury answered "yes" to the question, "Do the defendants possess monopoly power in any relevant market you found to exist?" In Question 4 the jury answered "yes" to "Have defendants attempted to monopolize in any relevant market in which they do not possess monopoly power?". The Court finds that the jury found monopoly power in all relevant markets. Plaintiffs in response to defendants' challenge do not list any markets in which defendants may not have possessed market power. Because defendants possessed monopoly power in all relevant markets asserted by plaintiffs, the answer to Question 4 cannot stand. The Court finds for defendants as a matter of law on Question 4, the attempt to monopolize claim.

Attempted monopolization customarily provides a cause of action when a plaintiff fails to prove monopoly power. A plaintiff may also attempt to monopolize in a market in which at first it does not possess monopoly power, but later succeeds in attaining monopoly power. Of course a defendant by definition attempts to do what it ultimately succeeds in doing, especially if the heightened intent requirement is met. Although plaintiffs meet the other requirements of a cause of action for attempted monopolization, given the wording of the question the cause of action for attempt in this instance must fail. This is of little significance because it does not affect the relief provided by the jury (damages) or by the court (equitable relief).

Defendants err in their contentions that plaintiffs did not suffer antitrust injury. Plaintiffs suffered antitrust injury for damages by paying supra-competitive prices and being excluded from the marketplace. Plaintiffs also suffered antitrust injury for injunctive relief because of the *threat* of continuing to pay supra-competitive prices and being excluded from the market in the future. Section 16 of the Clayton Act provides in part that "[a]ny person, firm, corporation, or association shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws." Sections

4 (the damages antitrust injury statute) and 16 of the Clayton Act "are thus best understood as providing complementary remedies for a single set of injuries." *Cargill, Inc. v. Monfort of Co., Inc.*, 479 U.S. 104, 113 (1986). Sections 16 and 4 differ in certain ways. Section 4 requires a plaintiff to show actual injury, but section 16 only requires plaintiff to show "threatened" loss or damage. *Id.* Section 16 requires plaintiff to show a threatened injury for which it would be entitled to compensation if the injury actually occurred. *Id.* at 112. Consequently plaintiff must allege threatened antitrust injury damage or loss "of the type the antitrust laws were designed to prevent and that flows from that which makes defendants' acts unlawful." *Id.* at 113.

There was sufficient evidence from which the jury could find that defendants conspired to monopolize. Defendants claim that plaintiffs did not prove a conspiracy to monopolize because they failed to rebut defendants' evidence of business justification for its predatory conduct, because there was no antitrust injury, and because plaintiffs did not connect the conspiracy with a specific market or impact. However, plaintiffs did provide sufficient evidence from which a jury could find that defendants conspired to monopolize. There was evidence that defendants conspired to control the Rice Clinic through a management services contract, (Tr. at 1092-1093), and that defendants conspired with the Gunderson Clinic to monopolize HMO services. (Tr. 1093-1094.)

Plaintiffs have also provided sufficient evidence from which the jury could find violations of section 1 of the Sherman Act for questions 6, 7, and 8 of the Special Verdict. Question 6 of the Special Verdict asked the jury whether defendants "entered into a contract, combination or conspiracy the purpose of which or predictable effect was to unreasonably restrain trade in any relevant market." Question 7 asked whether defendants engaged in four specific actions which are per se violations of the Sherman Act, (1) allocating customers, (2) allocating territory, (3) allocating product or service mar-

kets, or (4) fixing fees or prices. Question 8 asked whether the purpose or predictable effect of these four actions was to unreasonably restrain trade. Question 6 was provided on the Special Verdict to include any section 1 violations that were not specifically enumerated as per se violations in Questions 7 as well as encompassing those violations specifically enumerated in Question 7. Question 7 lists the actions which this Court held to be per se violations of section 1 in its Memorandum and Order Denying Plaintiffs' Motion for Summary Judgment. Question 8 applied the Rule of Reason and Joint Venture analysis to the per se violations in compliance with the Seventh Circuit's direction that a Rule of Reason analysis also be applied to per se violations in case courts differ on whether violations deserve per se treatment or Rule of Reason treatment because of the uncertain state of the law. *See General Leaseways Inc. v. National Truck Leasing Ass'n.*, 744 F.2d 588, 596 (7th Cir. 1984).

There is sufficient evidence in the record of violations of section 1. For example, there was evidence that Marshfield allocated markets and territory with Rhinelander Medical Center, Wausau area physicians and NCHPP. (Tr. at 865-868, 870-871.) There was evidence that Marshfield allocated outpatient and urgent care services with the Ministry Corporation. (Tr. at 927-929.) There was evidence of price-fixing between Marshfield and its affiliated providers. The affiliated providers had only one fee schedule for both Security and non-Security patients, (Tr. at 887-889), and Marshfield approved or disapproved it. (Tr. at 887-889.) This is not a straight buyer-seller relationship, it is a relationship of competing sellers. Additional evidence suggested that although HMOs generally pay 20-40% less than list price for physician services, (Tr. at 2308), Marshfield Clinic approved those prices at 100% of list. (Tr. at 868-870.) This price fixing resulted in supra-competitive prices in the Marshfield area. (Tr. at 127, 169.) The overall effects of these practices were supra-competitive prices and elimination or reduction of competition. For ex-

ample, the agreement between Marshfield and Rhinelander Medical Center to sign up with only one HMO, Security, and to drop NCHPP reduced competition. (Tr. at 712-713.) The contract with Wausau Medical Center which states that it cannot contract with other HMOs reduced competition. (Tr. at 1361.)

Contrary to defendants' contentions, it was the duty of the jury to weigh the evidence and balance the anti and pro competitive effects of the agreements at issue. The jury was properly instructed on both the Rule of Reason analysis and joint venture analysis. The role of the Court in a Rule 50 motion is not to reweigh the evidence, *Dombeck v. Milwaukee Valve Co.*, 823 F. Supp. 1475, 1477-78 (W.D. Wis. 1993), but to search the record for evidence of detrimental effects on competition. As stated above such evidence exists.

RULE 59, NEW TRIAL

When addressing defendants' motion for a new trial pursuant to Rule 59 the Court must consider whether the verdict is against the weight of the evidence, damages are excessive or trial is not fair to the moving party. *Forrester v. White*, 846 F.2d 29 (7th Cir. 1988).

Defendants claim they are entitled to a new trial on various other grounds to include the Court's failure to exclude the testimony of Jeffrey Nohl as an expert, the declination to give a statute of limitations instruction, improper instructions on plaintiffs' tying claims and that plaintiffs' evidence did not support their claim for lost profits.

The tying instructions provided by the Court were appropriate and necessary based upon the evidence presented. The statute of limitations instruction was provided in the damage phase of the trial as requested. The Court has also determined that Jeffrey Nohl with his 10 years experience in the HMO market but without the credentials of academia, a Phi Beta Kappa key or a price

tag in excess of $400,000.00 was nonetheless recognized as a witness by Rule 702 of the Federal Rules of Civil Procedure. The jury considered his experience and common sense discussion of the HMO market and regardless of the fact that he had not examined *Tunis* and believed a Buick was a separate product market, his testimony assisted the jury notwithstanding the complexity of this case.

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise. The standard instruction provided the jury with the necessary guidance for considering his testimony. Nohl's opinion was apparently accepted by the jury and as difficult as it may be for defendants to accept, the relevant product and geographical limits apparently were understood and found to exist. It was not error for Nohl to testify.

DAMAGES

Defendants are correct that the evidence does not support plaintiffs' claims for damages.

Dr. Christenson testified that Blue Cross paid Marshfield Clinic over the past 6 years in the range of 25 to 30 million dollars. He further testified that had the Marshfield Clinic charged the average fee of other physicians in the state of Wisconsin Blue Cross would have paid significantly less, "by approximately 35% of the total reimbursement to Marshfield." Magically, based upon plaintiffs' argument the jury determined that $10,500,000 would fairly and reasonably compensate plaintiff Blue Cross for any antitrust injury which it sustained on or after February 16, 1988 which is the direct result of defendants' conduct in violation of the antitrust laws. None of the Christenson testimony relates to any relevant

market found by the jury to exist, nor to any of the exhibits to which he referred.

More appropriately, Beyer addressed the overcharge fees in the context of the previously identified markets testifying that $813,222.00 would be attributed to the primary care market, $66,958.00 attributed to the pediatric market and $205,897.00 attributed to the specialty care market for a total of $1,085,897.00.

When compared to the offhand opinion of Christenson based upon no evidence in the record the $1,085,897.00 does not appear excessive. In contrast, the $10,500,000.00 is monstrously excessive. Dr. Beyer did attribute a portion of the overcharges, $491,014.00, to the ASO and Cost Plus contracts providing the jury an opportunity to select a lower damage figure of $594,833.00 which it did as shown by its response to Question 2 of the damage verdict. In any event Beyer declined to make those reductions stating, "In my judgment I thought that would be appropriate partly because it increased the number of and the amount of information that could be used or drawn upon for comparing the prices of physicians in these two different benchmark areas and also because, based on several sources of information, there was no reason to believe that there would be any significant differentiation by geographic area of these types of insurance, ASO and cost-plus throughout Wisconsin. There was no reason to exclude it and good reason to include it." (Tr. at 2595.)

The defendants' damage expert Mark Abernathy, however, did indeed provide those good reasons which the jury apparently accepted. "The ASO contract is a contract with an employer group simply to administer the claims for that particular employer group. And if the employer group wishes to cap his risk, then you can arrange for stop-loss insurance. The employer group bears the risk of loss. In an administrative service contract

(ASO), you're simply processing claims for patients having health care and charging the fee for processing those claims. It's my opinion that it would be inappropriate to include ASO and self-insured contracts to damages calculations to Blue Cross/Blue Shield simply because Blue Cross/Blue Shield passes the claims through to the employer, they don't bear the expense of the claim."

Initially a plaintiff in an antitrust action has the burden to prove the fact of the injury—that defendants' conduct was a material cause of some injury to plaintiff's business. Once plaintiffs have established the fact of injury the burden of proving the amount of damages is more relaxed. *Moore v. Boating Industry Assoc.*, 754 F.2d 698, 717 (7th Cir. 1985) *vacated on other grounds*, 474 U.S. 895 (1985). Once causation of damages in an antitrust case has been established the *amount* of damages may be determined by a "just and reasonable estimate." *MCI Communications, Co. v. AT&T*, 708 F.2d 1081, 1161 (7th Cir. 1983). Since the Supreme Court has allowed for some measure of uncertainty in the calculation of antitrust damages, strict proof of which damages have been caused by which acts has not been required. *Id.* The Seventh Circuit, however, went on to hold that a damage award must reflect only those losses directly attributable to unlawful competition. *Id.* at 1161. The court in *MCI* ordered a new trial on damages because the damage study relied on by the jury in its damage award did not subtract those damages attributable to lawful competition. Nor was the jury provided with a methodology to reduce the amount of damages by the amount of lawful conduct. The Court noted the distinction between proof of causation of damages and proof of an amount of damages and reasoned that courts have been consistent in requiring plaintiffs to prove in a reasonable manner the link between the injury suffered and the *illegal* practices of the defendant.

A remittitur is appropriate in the case at bar even in light of the lower burden on a plaintiff in an antitrust action to prove the *amount* of damages. The damage award is clearly excessive, totally monstrous, contrary to the evidence presented at trial and based on a figure lacking adequate foundation. The error in the damage award to *Blue Cross* is somewhat analogous to the error in the damage award in *MCI*. The damage award to *Blue Cross* lacks testimony relating to the relevant markets and those markets in which defendants had market power. Without this information there is no casual link between essential elements of the cause of action and the damage award. Defendants are liable only for those damages directly caused by their illegal conduct. They are not liable for a percentage of all payments made to them by Blue Cross. Such an amount could reflect payments that are not the result of defendants' illegal conduct. Testimony relating overcharges to the relevant markets and the markets in which defendants had monopoly power is necessary to prove that those are the damages caused by illegal conduct. Such a requirement is not too onerous because plaintiff presented testimony relating damages to the relevant markets via Dr. Beyer.

As precise as Dr. Beyer was in addressing the overcharge damages to which Blue Cross/Blue Shield was entitled he was somewhat speculative in his approach when assessing those damages to be provided to plaintiff Compcare as a result of the defendants' foreclosure of HMO services to plaintiffs. He testified that an amount of damage in the Greater Marshfield area would be somewhere between 3.1 to 4.9 million dollars. He justified the higher amount based upon that evidence which demonstrated a cost shifting by the defendants. Evidence was provided in the testimony of Dwight Ruff and those memos to which he referred that Marshfield had the desire to minimize profits in its HMO because of its public and regulative nature. Defendants were obviously and

admittedly in a position to set the capitation rate at any level in order to show profits in one entity or the other. Its actual numbers generally showed a large increase in the capitation rate in 1993 which skewed the profits from about 50/50 to substantially in the clinic's favor. The 1993 capitation rate increase was about $8.00 yet the amounts added by Beyer for the cost shift was only $2.00 and $4.00. This amount seems likely to be less than the actual cost shift. Furthermore, the approximately one million dollar projected annual profit, even with the cost shift, is less than 20% of the average annual profit which Marshfield was realizing from its HMO. Although Beyer's estimate of the amount of cost shift may be speculative it was necessarily so because the information which went into that shift is exclusively within Marshfield's knowledge and is difficult to discern from available records. In conclusion under all of the circumstances the amount of lost HMO profits testified to by Beyer and accepted by the jury cannot be judged unreasonable.

While speculative in part the computation of HMO lost profits generally addreses a conservative approach and does not produce an unreasonably high result. Granting a remittitur is necessary because the jury added to Compcare's lost profits of $5,056,277.00 the amount of over charge damages in the amount of $594,883.00 which should have been awarded to Blue Cross at Question 1. (Exhibit 10413, attached) Accordingly the amount as found by the jury, $5,669,277.00 shall be reduced by said amount.

"For years we have been saying, without much visible effect, that people who want damages have to prove them, using methodologies that need not be intellectually sophisticated but must not insult the intelligence. *Post hoc ergo propter hoc* will not do; nor the enduing of simplistic extrapolation and childish arithmetic with the appearance of authority by hiring a professor to mouth

damages theories that make a joke of the concept of expert knowledge." *Schiller & Schmidt, Inc. v. Nordisco Corp.*, 969 F.2d 410, 415-416 (7th Cir. 1992) (Citations omitted).

This Court has determined that the defendants are entitled to a new trial on damages because they are monstrously excessive based upon that legally sufficient evidence which the jury failed to consider.

Accordingly, a remittitur will be entered where defendants are granted a new trial subject to an award of $594,883.00 to plaintiff Blue Cross and Blue Shield United of Wisconsin and $5,074,394.00 to plaintiff Compcare Health Services Insurance Corporation, amounts to be trebled by the Court. In the event plaintiffs fail to accept the remittitur set forth herein on or before April 3, 1995, a new trial on damages will be scheduled.

EQUITABLE RELIEF

Plaintiffs have requested broad, far-reaching equitable relief. Defendants have responded by denying the need for any injunctive relief or for limited injunctive relief in the alternative.

Section 16 of the Clayton Act provides:

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws . . . when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damages is granted by courts of equity, under the rules governing such proceedings. . . .

It is plaintiffs' burden to prove they are entitled to injunctive relief. *Wilk v. American Medical Ass'n.*, 895 F.2d 352, 366-367. (7th Cir. 1990) To be entitled to equitable relief plaintiffs must demonstrate (1) antitrust in-

jury, (2) that no adequate remedy at law exists, and (3) that the balance of hardships favors the imposition of equitable relief. *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 114 (1986); *Wilk*, 895 F.2d at 370. Traditional principles of equity apply under section 16. *Id.* Equitable relief is discretionary and not automatically available to an injured plaintiff. *Id.* The sole function of an action for injunction is to forestall future violations. *U.S. v. Oregon State Medical Soc.*, 343 U.S. 326, 333 (1952). It is unrelated to punishment or reparation. *Id.* A threat of future violation or contemporary violation of a nature likely to continue or recur is necessary for injunctive relief. *Id.; Wilk*, 895 F.2d at 367. Section 16 should be construed and applied with the purpose of enforcing the antitrust laws and with the knowledge that the remedy it affords, like other equitable remedies is "flexible and capable of nice 'adjustment and reconciliation between the public interest and private needs as well as between competing private claims.' " *Zenith Radio Co. v. Hazeltine Research, Inc.*, 395 U.S. 100, 131 (1969).

Instead of considering those post trial affidavits and other related documents, the Court refers to the record as stated earlier for that relief which should be addressed. The following testimony of Glassman is a part of that evidence which a court of equity should consider when granting injunctive and declaratory relief.

> My 4th conclusion is that if Marshfield Clinic is forced to do business in the fashion desired by Blue Cross and Compcare that competition will be harmed and that the consumers of Central and North Central Wisconsin will be left worse off because of that.

The first requirement for injunctive relief, antitrust injury, clearly exists and has been previously addressed in this Memorandum, this Court's Memorandum and Order Denying Defendants' Motion for Summary Judgment, and in the Special Verdict. As for the second requirement,

that there be no adequate remedy at law because of a threat of future violations, plaintiffs have argued that defendants have not admitted any wrongdoing and in fact vehemently deny their actions in any way violate the antitrust laws. To be considered in this analysis are the bonafides of the expressed intent to comply with the antitrust laws, the effectiveness of the discontinuance of the violations of the law and in some cases the character of the past violations. *Wilk*, 895 F.2d at 367. The court in *Wilk* considered as a factor in support of an injunction the failure of the defendant AMA to ever acknowledge that its practice of discriminating against osteopaths was illegal. Here, the monetary relief has been found adequate to provide relief to plaintiffs for the pecuniary loss they have already sustained and will sustain. The reasoned and substantial award of damages is likely to motivate defendants to change their behavior. Defendants, however, continue to deny any wrongdoing. Consequently, there is a threat that defendants will continue to violate the antitrust laws. The third element, balancing the hardships, (referred to by Glassman among others at trial) has been analyzed separately according to each type of injunctive relief requested.

Plaintiffs suffered two forms of antitrust injury as a result of defendants' violation of the antitrust laws, paying supra-competitive prices and Compcare's exclusion from the HMO market. Plaintiffs request equitable relief to restore competitive pricing for medical services in the relevant markets to ensure against future supra competitive prices. Plaintiffs also request equitable relief to allow Compcare to enter the HMO services market by guaranteeing access to Marshfield physicians to form an HMO and request that Marshfield be divested of its subsidiary, Security.

Plaintiffs request the divestiture of the Lakeland and Flabeau Clinics from the Marshfield Clinic. A court may order divestiture as part of injunctive relief in an

action between private parties in suits under section 16. *California v. American Stores Co.*, 495 U.S. 271, 295 (1990). However this does not mean that such power should be exercised in every situation in which the Government would be entitled to relief under section 15. Plaintiffs in their Trial Brief in Support of Injunctive Relief did not cite to a single case in which *retroactive* divestiture was awarded in a *private* section 1 or 2 case. The only case cited was *International Travel Arrangers v. NWA, Inc.* 723 F. Supp. 141 (D. Minn. 1990), *aff'd.*, 991 F.2d 1389 (8th Cir.), *cert. denied*, 114 S.Ct. 345 (1993) which stated in dicta that divestiture is available in private sections 1 and 2 suits. Divestiture has been awarded in section 7 cases in the context of proposed mergers and in cases brought by the government. "Potentially disruptive remedies such as divestiture of completed transactions involving integration of ongoing business activities have never been granted in private suits under section 7." *Glendora v. Gannette*, 858 F.Supp. 369, 372 (S.D.N.Y. 1994) *aff'd.* 40 F.3d 1238 (2nd Cir. 1994). Indeed the Seventh Circuit upheld the district court's refusal to order defendants to divest the Bulls franchise as an equitable remedy for their illegal conduct in *Fishman v. Estate of Wirtz*, 807 F.2d 520 (7th Cir. 1986).

It is questionable whether divestiture of a long completed transaction is an appropriate remedy in a private action under the Sherman Act. In any event it is not an appropriate remedy here. Divestiture of the Lakeland and Flambeau clinics would require Marshfield to sell its ownership interest in the former Lakeland Medical Center (which includes sale of physician practices in Minoqua/ Woodruf, Park Falls, Phillips and Mercer) and in the Flambeau Medical Center Hospital. Less drastic remedies are available which are designed to halt anti-competitive conduct and agreements. Moreover the balance of equities does not favor divestiture. The Marshfield Clinic came into these areas at the request of local providers who

requested Marshfield to preserve and expand the access to care. (Tr. at 1282-1290.) Divestiture would have a large impact on third parties such as patients, Marshfield doctors and others that have not been before this Court to protect their interests.

The next category of relief requested is to void and prohibit all contracts, combinations and conspiracies in restraint of trade. A court should enjoin the precise practices found to have violated the Act. *United States v. Grinnell Co.*, 384 U.S. 563, 579 (1966); *see U.S. v. Crescent Amusement Co.*, 323 U.S. 173, 188 (1944) ("Civil suits under the Sherman Act would indeed be idle gestures if the injunction did not run against the continuance or resumption of the unlawful practice.) Injunctive relief should be fashioned to prevent the recurrence of the illegality which brought on the given litigation. *United States v. Loew's, Inc.*, 371 U.S. 38, 52 (1962). To ensure that relief is effectual, otherwise permissible practices connected with the acts found to be illegal must sometimes be enjoined. *Id.*, at 53.

Plaintiff request that Marshfield and Security be enjoined from entering into or enforcing certain agreements with the Gunderson Clinic, Rice Clinic, Wausau area physicians, the North Central Health Protection Plan, and Rhinelander Medical Center concerning (1) administrative services, (2) administration of health plans, (3) allocation of customers, territories, product or service markets, (4) setting of fees or prices, (5) free flow agreements, and (6) marketing. These types of agreements have the effect of reducing competition. Prohibiting them is an appropriate remedy for a monopolist guilty of past anti-competitive conduct to reduce the threat that such anti-competitive conduct will continue. If defendants are involved in the supervision of a competitor where they have access to information that can help them reduce competition they can influence that provider to reduce competition. Thus supervision of competitors will be en-

joined, but providing purely administrative services will not. If defendants are involved in the administration of the health plans of their competitors, they can reduce competition. Allocation of customers, territories, products or service markets are acts which are per se illegal as is price fixing. Defendants involvement with its competitors' marketing can also limit competition but such limitation is not found to be necessary here.

For example, The Gunderson Clinic, located in La-Crosse, consists of 270-300 doctors, is one of the 5 largest medical group practices in Wisconsin and competes with Marshfield. There was reasonable evidence in the record from which the jury could find defendants conspired to monopolize by controlling the Gunderson Clinic. Marshfield has a contract to provide certain administrative services for Gunderson. (Tr. at 1094.)

The Rice Clinic, located in Stevens Point, is also one of defendants' competitors. There was reasonable evidence from which a jury could find that Marshfield conspired with the Rice Clinic to monopolize physician services. Marshfield engaged in negotiations to acquire Rice. (Tr. at 1092-1093.) Marshfield now has a management services contract with Rice. Marshfield serves as manager and where Rice requires administrative services it must ask Marshfield to provide it first. (Tr. at 1092.) This is the same type of agreement Marshfield had with Lakeland before Marshfield acquired it.

There was also sufficient evidence from which a jury could find that Marshfield and Wausau area physicians conspired to monopolize physician services. Marshfield and Wausau agreed not to enter competing agreements with other HMOs for their Security 65 HMO. (Tr. at 1361-1363.) Marshfield also attempted to purchase/affiliate with Wausau Medical Center. (Tr. at 1315-1316.) The North Central Health Protection Plan is an HMO operating with Wausau area physicians. There is evidence from which a jury could find that Marshfield

and Security divided territory with NCHPP in violation of section 1. NCHPP can only be sold in certain areas and Security in others. The two plans market separately. (Tr. at 856-857.) The Rhinelander Medical Center uses NCHPP in Lincoln County only and uses Security in Oneida County only. (Tr. at 865-866, 870-871.)

Rhinelander Medical Center near Lakeland competes with Marshfield. (Tr. at 862.) It has about 30 doctors all of whom are either Marshfield doctors or affiliated with Security. (Tr. at 712-713.) There is evidence in the record from which a jury could find that Marshfield allocated territory with Rhinelander. (Tr. at 865-868, 870-871.) Marshfield warned Rhinelander about signing with more than one HMO. Rhinelander then cancelled NCHPP in Oneida county in favor of a relationship with Security. (Tr. at 712-713.) Rhinelander participates in NCHPP in Lincoln County and participates in Security in Oneida County only. (Tr. 865-866, 870-871.)

Defendants object to this relief on numerous grounds. They claim this would void beneficial agreements. While these agreements have some beneficial attributes, they tend to reduce competition. A monopolist found guilty of illegally conspiring with competitors to reduce competition simply should not be involved in the supervision of its competitors. Nor should a monopolist engage in a free flow agreement with a competitor because it reduces the chances that the competitors will expand into each other's markets. Fee setting and market allocation speak for themselves. The risks of anti-competitive conduct outweigh the limited benefits the agreements may provide. Defendants express concern that they will no longer be able to provide certain physician services that are needed in other areas. Nothing in this order prevents Marshfield from providing physician services for competitors.

Next, plaintiffs request that defendants be enjoined from entering into or enforcing any agreement which pro-

hibits Marshfield physicians from providing cross-coverage. The jury was instructed that it could find liability only if it found barriers to entry in the relevant markets. The inability to obtain cross-coverage was considered to be a barrier to entry for independent physicians attempting to practice in the rural areas of the relevant markets. Contrary to customary rural practice Marshfield's policy was to refuse cross-coverage to independent physicians. (Tr. at 553, 588, 489, 500.) Marshfield in fact denied such cross-coverage. (Tr. 501, 526, 463, 353, 397, 480.) While defendants complain about the problems of insurance when providing cross-coverage for non-Marshfield physicians, any problem posed by liability coverage is outweighed by the need to lift barriers to entry for independent physicians in order to open the Marshfield market to competition.

Plaintiffs request that defendants be enjoined from entering into or enforcing any non-compete or other exclusivity agreements which restrain the ability of physicians employed by Marshfield to practice in any location after terminating employment with the Marshfield Clinic. Marshfield employed doctors are currently required to sign non-compete contracts. (Tr. at 711.) Defendants assert that these agreements are required to protect their investment in recruiting and training physicians. Normally these agreements, if reasonable, are enforceable but when utilized by an illegal monopolist they are not justified. Prohibiting these agreements could help to open the relevant markets to competition. Defendants have asserted in opposing divestiture that many Marshfield doctors would leave the area without the support of Marshfield. If this is valid, defendants have no concerns because even in the absence of such restrictive covenants, Marshfield doctors will not leave.

Plaintiffs further request that any agreements requiring referrals of patients by any physicians or other providers to the Marshfield Clinic or its physicians be prohibited.

This practice created the illegal monopoly in specialty physician services and should cease. However, any agreements which require as part of the Security HMO that Marshfield physicians and physicians who are part of the Securtiy HMO network refer Security HMO patients only to physicians that are part of the Security HMO are valid. Using a distinct panel of doctors is the very essence of an HMO. The practice is only anti-competitive when patients who are not a part of the security HMO are referred exclusively to Marshfield Clinic. There is no justification for such an anti-competitive policy as requested by plaintiffs.

Next plaintiffs request an injunction prohibiting defendants for a period of five years from entering into any agreement or understanding to acquire, administer or control any presently existing independent physician, physician group, clinic or hospital, HMO except Security, or managed care network. Providing this relief as to the Gunderson Clinic, Rice Medical Center, Wausau Medical Center, and NCHPP should prevent defendants from expanding their monopoly and from further reducing competition by taking over competitors. There is a great risk that Marshfield will engage in such activity in the future because it has systematically taken over physician practices in the past. There is also evidence that it has attempted to control or acquire these clinics. (Tr. at 1094, 1092-1093, 1315-1316.) Any potential harm from this restriction is outweighed by the danger posed by Marshfield expanding its monopoly and forcing other potential competitors from the market. This does not prevent Marshfield from starting a new practice or entering competitive markets, so there is no danger that this injunction would harm an under-served area.

Next plaintiffs request an injunction prohibiting defendants from comprising more than 30 percent of the number of physicians of any committee intended to review, recommend, approve or restrict privileges at any hospital or participating in any peer review process at any

hospital. This request is harsh and its purpose may be accomplished by other means. Its purpose is to remove a barrier to independent physicians attempting to enter the market. The barrier is the inability of independent physicians to obtain approval for staff privileges at various hospitals where the credentialing committees were dominated by Marshfield doctors. There was evidence that Marshfield physicians restricted hospital privileges of competitors. (Tr. at 358-363, 399-401.) The injunctive relief which prohibits Marshfield from adopting any practice which limits hospital privileges of qualified doctors not employed by Marshfield is sufficient to accomplish this purpose.

Plaintiffs request an injunction to prevent defendants from entering into any agreement, adopting any practice or attending any meeting with the Ministry Corporation or its representatives concerning (1) joint marketing; (2) ownership, control, administration or operation of any health care facility; (3) plan for regional development health care; (4) recruitment; (5) allocation of territories, customers, products or services; (6) setting fees or prices and (7) service to be provided by Ministry Corporation Hospital to or for any health care insurer. Ministry corporation is involved in operating hospitals in the Marshfield area. Ministry and Marshfield have marketed certain specialty care items together and have engaged in joint planning where Ministry purchases certain equipment and Marshfield recruits the personnel to use it. Ministry and Marshfield are competitors for certain items such as outpatient surgery. There was evidence in the record from which a jury could find that Marshfield and the Ministry corporation allocated territory for outpatient care, emergency, or urgent care. (Tr. at 927-929.) Defendants have pointed to certain benefits such as cost savings that outweigh the potential risks to competition. However, in those areas in which they are competitors, they are enjoined from allocating territories, customers, products or

services and from setting fees or prices. These activities are always illegal between competitors.

Defendants will be enjoined from entering into any agreement which affiliates any physician with Security Health Plan based in whole or part on whether such physician is employed by Marshfield or Rhinelander Medical Center. This will open competition and give independent physicians willing to be paid at the Security rate a chance to have more patients. This should not harm defendants because they are not ordered to affiliate with all interested physicians.

Plaintiffs also request an injunction prohibiting Marshfield from entering into any agreement which restricts the location at which a physician affiliated with Security Health Plan may provide services for which Security Health Plan will allow reimbursement. An HMO cannot have an unlimited number of affiliated physicians in different geographic areas. Having some reasonable limits on the number of physicians in an area allows an HMO to be cost effective. Limitations on where an affiliated physician may practice and receive reimbursement for HMO patients does not preclude that physician from seeing non-Security patients in other areas.

Finally, plaintiffs ask the Court to set price levels for defendants' services. Plaintiffs allege that this will force defendants to finally sell at a competitive price. This Court refuses to micro-manage the health care economy in North-Central Wisconsin and has provided reasonable injunctive relief. This relief is intended to open the market to competition and is crafted to allow the market to self-adjust to competitive pricing.

ORDER

IT IS ORDERED that defendants' motion for judgment as a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure, is GRANTED as to

Question 4 of the Special Verdict and DENIED in all other respects.

IT IS FURTHER ORDERED that defendants' alternative motion for new trial on liability pursuant to Rule 59 of the Federal Rules of Civil Procedure is DENIED.

IT IS FURTHER ORDERED that defendants' motion for a new trial on damages is GRANTED unless the aforesaid remittitur is accepted by the plaintiffs as set forth herein.

IT IS FURTHER ORDERED that any acceptance of remittitur by the plaintiffs shall be trebled by the Court and amended judgment to include costs, reasonable attorneys fees and expenses shall be entered together with that injunctive relief which follows:

I. JURISDICTION

This Court has jurisdiction over the parties and subject matter. Jurisdiction is retained by this Court for the term of this Order to enable any of the parties to this Order to apply to this Court at any time for the construction or implementation of the Order, for the enforcement or modification of any of its provisions and for sanctions for any violation thereof.

II. DEFINITIONS

A. "Agreement" shall be broadly construed to include all agreements, understandings and contracts, whether written, oral or otherwise.

B. "Central and north central area" shall mean the following counties: Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Florence, Forest, Iron, Jackson, Juneau, La Crosse, Langlade, Lincoln, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Portage, Price, Rusk, St. Croix, Sawyer, Shawano, Taylor, Trempelau, Vilas, Washburn, Waupaca, Waushara and Wood.

III. APPLICABILITY

This final Order applies to each defendant and to each of the defendants' officers, board members, administrators, agents, servants, representatives, employees, successors, and assigns.

IV. VOID CERTAIN AGREEMENTS

Defendants Marshfield Clinic and Security Health Plan are enjoined and restrained from directly or indirectly entering into or enforcing any of the following Agreements, understandings and other described actions and a Declaration is hereby made that such Agreements, understandings and described actions are void and of no effect, as follows:

A. Any agreements or understandings with the Gunderson Clinic concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

B. Any Agreements or understandings with the Rice Clinic concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

C. Any Agreements or understandings with Wausau area physicians concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

D. Any Agreements or understandings with North Central Health Protection Plan concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices; and
5. Free flow of health plan patients.

E. Any Agreements or understandings with Rhinelander Medical Center concerning:

1. Administration of health plans;
2. Allocation of customers, territories, product or service markets;
3. Setting of fees or prices;
4. Free flow of health plan patients.

F. Any Agreements or understandings which directly or indirectly limit, prohibit or tend to limit or prohibit Marshfield physicians from providing cross-coverage to non-Marshfield physicians.

G. Any Non-Compete or other Exclusivity Agreements or understandings which directly or indirectly prohibit or restrain the ability of a Marshfield employed physician from practicing in any location after terminating employment with the Marshfield Clinic.

H. Any Agreements or understandings requiring referrals of patients by any physicians or other provider to the Marshfield Clinic or its physicians except for Security HMO patients.

V. PROHIBITED CONDUCT

Marshfield Clinic and Security Health Plan are enjoined and restrained for a period of three (3) years from the following:

A. Entering into any Agreement or understanding to directly or indirectly acquire, supervise or control the Gunderson Clinic, the Rice Clinic, the Wausau area physicians and NCHPP.

B. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any type or kind which directly or indirectly may tend to in any way limit or prohibit cross-coverage of any physician not employed by the Marshfield Clinic;

C. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any type or kind which directly or indirectly may tend to prohibit or limit hospital privileges of any qualified physician not employed by Marshfield Clinic;

D. Entering into any Agreement, having any policy, adopting any practice or procedure or attending any meeting with the Ministry Corporation or its representatives concerning:

1. Allocation of territories, customers, products or services;

2. Setting of fees or prices.

E. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any kind which directly or indirectly affiliates any physician with the Security Health Plan based in

whole or in part on whether such physician is employed by the Marshfield Clinic or Rhinelander Medical Center.

VI. EQUAL ACCESS

A. The defendants Marshfield Clinic and Security are enjoined from discriminating against Blue Cross/Compcare in providing them access to its physicians, products and services for the purposes of establishing an HMO in the Greater Marshfield and Northcare areas.

B. The defendants Marshfield Clinic and Security are enjoined from charging supra-competitive prices for their services and products.

VII. COMPLIANCE PROGRAM

Marshfield Clinic and Security Health Plan shall maintain an antitrust compliance program which shall include:

A. Distributing within thirty (30) days from the entry of this Order, a copy of this Order to all their respective officers, directors, trustees, administrators and employees.

B. Notifying the Marshfield Clinic and Security Health Plan officers, directors, trustees, administrators, employees, and affiliated physicians within thirty (30) days from the entry of this Order that they are not bound by any agreement described herein as void.

C. Distributing in a timely manner a copy of this Order to any successor corporation or person who succeeds to a position as officer, director, trustee, administrator, employee or affiliated physician.

D. Holding a briefing annually for all operating officers, directors, and administrators concerning the meaning and requirements of this Order.

E. Obtaining from each operating officer and administrator an annual, signed written certification pursuant to 28 U.S.C. § 1746 that he or she has: (1) read, understands and agrees to abide by this Order; (2) has been advised and understands that noncompliance with this

Order may result in sanctions; and (3) is not aware of any violation of this Order.

F. Maintaining for inspection by plaintiffs a record of recipients to whom this Order has been distributed and from whom the certification required by Paragraph VII. E. has been obtained; and

G. Conducting an audit of its activities within sixty (60) days from the entry of this Order and annually thereafter to determine compliance with this Order.

VIII. CERTIFICATIONS

A. Within thirty (30) days after the entry of this Order, each defendant shall certify to plaintiffs and the Court whether it has made the distribution of this Order and made the necessary notifications in accordance with Paragraph VII A. and VII B. herein.

B. For three (3) years after the entry of this Order, on or before its anniversary date, each defendant shall certify annually to plaintiffs whether defendants have complied with the provisions of Paragraph VII., Sections C, D, E, F and G.

IX. NOTICE AND PUBLICATION

Marshfield Clinic and Security Health Plan shall provide by first class mail, postage pre-paid, a copy of this Order to the following persons within thirty (30) days of the entry of this Order:

A. All physicians practicing in the central and north central Wisconsin area;

B. All hospitals located within the central and north central Wisconsin area;

C. All Security Health Plan affiliated physicians;

D. Rhinelander Medical Center;

E. Gunderson Clinic;

F. North Central Health Protection Plan;

G. Wausau Clinic;

H. Rice Clinic; and

I. Rice Lake Clinic.

X. EXPIRATION OF ORDER

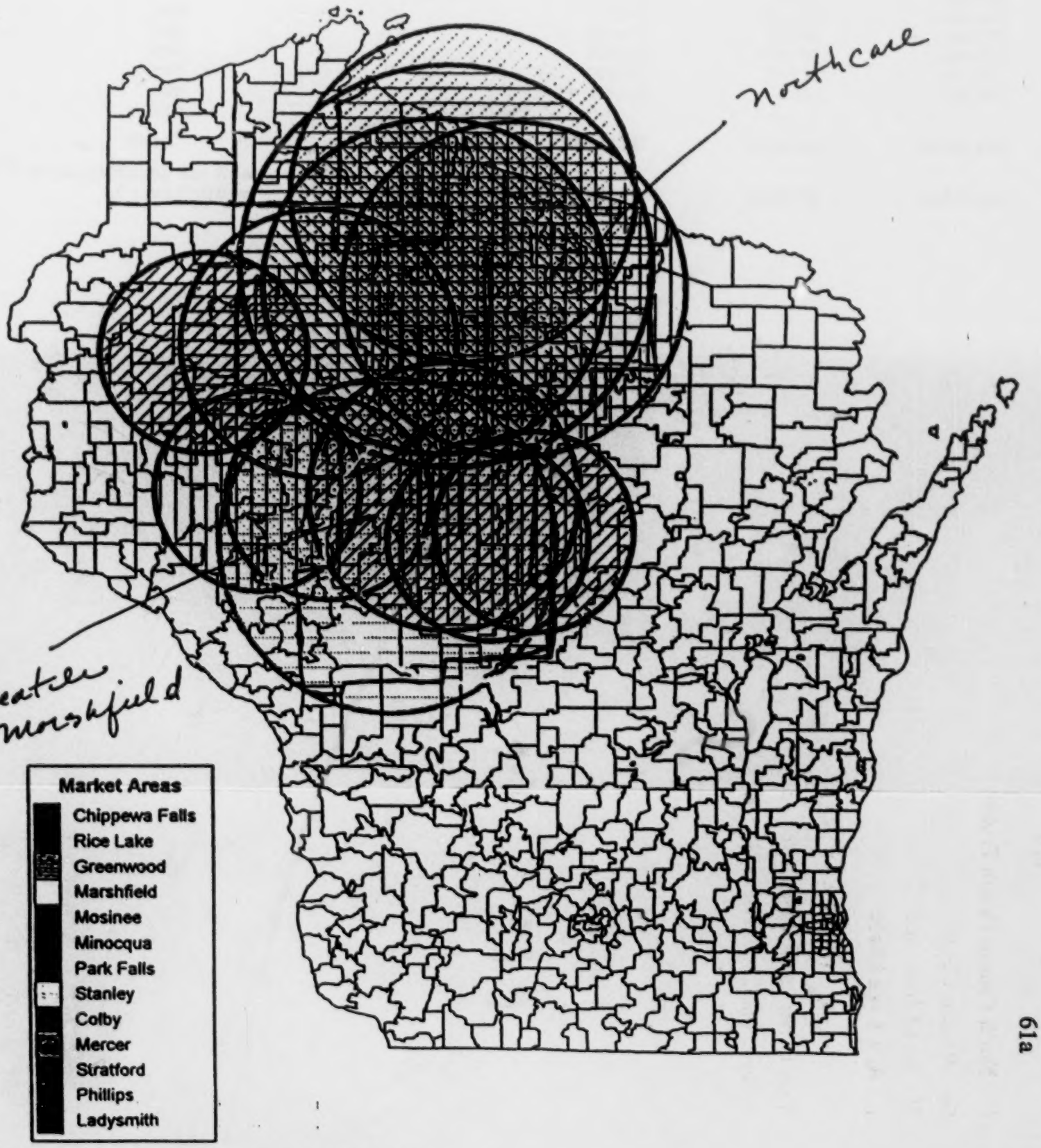
This Order shall expire three years from this date.

Entered this 22nd day of March, 1995.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

Dr. Greenberg's Primary Care Markets



Source: Report of Warren Greenberg, Exhibit 6

Summary of Damages Incurred by Blue Cross and Compcare

	Damages Due to Higher Physician Fees (Based on Indemnity Payments Only)	Damages Due to Foreclosure into GMHP Area	Damages Due to Foreclosure into Northcare Area	Total Damages
	(dollars)			
1988	$ 69,092	—	—	$ 69,092
1989	179,726	—	—	179,726
1990	113,462	(150,000)	—	(36,538)
1991	89,766	127,500	(25,500)	191,766
1992	85,557	617,571	(15,431)	687,697
1993	57,280	367,570	80,875	505,725
1994	—	719,268	(93,812)	625,456
1995	—	459,272	21,300	480,572
1996	—	506,159	(16,507)	489,652
1997	—	304,475	13,116	317,591
1998	—	176,166	6,324	182,490
1999	—	—	—	
Total	$594,883	$3,127,981	($29,635)	$3,693,229
Total—Reducing the Effect of Cost-Shifting	$594,883	$4,920,299	$135,978	$5,651,160

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
CHICAGO, ILLINOIS 60604

October 13, 1995

Before

Hon. Richard A. Posner, Chief Judge

Hon. William J. Bauer, Circuit Judge

Hon. Michael S. Kanne, Circuit Judge

Nos. 95-1965, 95-2140

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
and COMPCARE HEALTH SERVICES
INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellants,
Cross-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin

No. 94 C 137S—John C. Shabaz, *Judge*

ORDER

Upon consideration of the petition for rehearing and the brief of the United States and the Federal Trade Commission in support of the petition, the slip opinion in this matter, issued on September 18, is amended as follows:

P. 3, after first full sentence, beginning "These contracts are not exclusive . . .": the following sentence is inserted: "(Compcare argues that the 6 percent figure is found only in a study and testimony excluded from evidence, but our reading of the objection to the testimony and the ruling on that objection is that not the figure, but only the witness's effort to characterize it as insignificant, was excluded.)"

P. 6, after last full sentence on page, ending "a separate market.": the following sentence is inserted: "(We emphasize "record compiled in the district court." Terms such as "HMO" and "PPO" are used to refer to a variety of different types of plan, which may vary in respects crucial to antitrust liability.)"

P. 9, first sentence after paragraph break: "because HMOs are not a market" is changed to "because, subject to our earlier qualification, HMOs are not a market".

P. 16, before paragraph break: at end of preceding paragraph (ending "1338") the following new sentence is inserted: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case."

Save for these amendments to the slip opinion, the petition for rehearing is DENIED.

APPENDIX D

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellants,
Cross-Appellees.

On Appeal from the United States District Court
for the Western District of Wisconsin

BRIEF FOR THE UNITED STATES AND THE FEDERAL TRADE COMMISSION AS AMICI CURIAE IN SUPPORT OF PETITION FOR REHEARING

INTEREST OF THE UNITED STATES AND THE FEDERAL TRADE COMMISSION

The United States and the Federal Trade Commission are principally responsible for enforcing the federal antitrust laws and have been active in the health care area.

In the last 18 months, the Department of Justice and the Commission have filed over 20 antitrust health care cases, have jointly issued the "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust," and have issued numerous business reviews and advisory opinions to health care providers. Currently, the Department and the Commission are conducting over 80 health care investigations. Thus, the United States and the Commission have a strong interest in the clear articulation and proper application of antitrust principles in this area.

STATEMENT

Plaintiff Blue Cross/Blue Shield is a health insurer; its subsidiary, Compcare, is a Health Maintenance Organization (HMO). Defendant, Marshfield Clinic is a physician-owned clinic; it owns Security, an HMO.

Blue Cross filed suit against Marshfield, alleging violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and related state law violations. Blue Cross claimed that Marshfield had monopolized the HMO market and injured Blue Cross (as a potential competitor in that market through Compcare) by refusing to allow Marshfield doctors to deal with HMOs competing with Security, thus denying access to an "essential facility." In addition, Blue Cross claimed that Marshfield's monopolization of various health care markets and its related anticompetitive agreements with other health care providers resulted in supracompetitive prices for medical services, which injured Blue Cross as a purchaser of such services for its subscribers.

The jury found in favor of plaintiffs on all of a series of special verdicts and found damages of over $15 million. Defendants moved for judgment as a matter of law and for a new trial. The district court upheld the jury verdicts on liability, but granted a new trial (subject to a remittitur) on damages. It also entered an injunction, which this Court stayed pending appeal.

This Court reversed. It held that the record could not support a finding that HMOs constitute a relevant market, and thus that Security could not be liable for monopolizing HMO services. It also concluded that Marshfield does not have a monopoly share of physician services because it does not control the independent physicians who provide services under contractual arrangements with Marshfield and Security, and that monopoly power could not be inferred from Marshfield's prices.

With respect to the section 1 claim, the Court held that no collusion between Marshfield and its affiliated (non-employee) physicians had been proved because the only evidence of "collusion" was that Marshfield "would not pay them more than what these physicians charge their other patients," and this "is not price fixing." Slip op. at 15-16. The Court, however, found the evidence of market division "a little scanty, [but] sufficient to sustain the jury's verdict." *Id.* at 17. It remanded for revision of the injunction in accordance with its opinion and a new trial limited to damages for market division. *Id.* at 17-19.

DISCUSSION

The United States and the Federal Trade Commission take no position on the sufficiency of the record to support the jury's verdict. We are concerned, however, that the Court's explanations of its conclusions on two issues may mislead readers unfamiliar with the record and arguments in this case as to the law applicable to market definition and analysis of "most-favored-nation" ("MFN") agreements—issues that frequently arise in health-care antitrust cases.

1. *Market Definition.* As this Court has recognized, market definition is a factual question. Slip op. at 3; *see also Brown Shoe Co. v. United States*, 370 U.S. 294, 326 (1962); *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1283-85 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990); *Fishman v. Estate of Wirtz*, 807 F.2d 520,

531 (7th Cir. 1986). Accordingly, this Court's holding that the record in this case contains no evidence to support the jury's finding that HMOs comprise a separate market from other forms of health care delivery should not preclude a finding on a different record of a relevant product market limited to HMOs. *See U.S. Healthcare v. Healthsource, Inc.*, 986 F.2d 589, 598-99 (1st Cir. 1993) (recognizing that HMOs could be a separate market from other forms of health care financing, but concluding that plaintiffs had not so proved).

We are concerned, however, that the Court's statement that "HMOs are not a market" (slip op. at 9) might be read inappropriately out of context, to establish a rule of general applicability. Such a misinterpretation would be extremely unfortunate, for market definition in a health care antitrust case requires careful attention to the facts. Terms such as "HMO" or "PPO" can refer to a range of health care plans that vary widely in price, quality, features, and the extent to which they compete with one another. Health care markets are evolving rapidly, as providers and purchasers search for more efficient delivery systems. Thus, it is of critical importance that lower courts avoid any temptation to substitute reliance on generalizations or assumptions about the functioning of health care markets for careful analysis of the evidence presented in a particular case. In particular, we are concerned that the Court's observation that "the price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from [other] forms of medical services contracting," (slip op. at 5) could be misinterpreted as a holding that any competition between two health care products necessarily forecloses the possibility that they are separate markets. As this Circuit has recognized, the products included in a relevant antitrust market "may not exhaust the alternatives open to [consumers]." *Rockford*, 898 F.2d at 1284. The question is the extent to which customers are likely to shift to various alternatives if prices for a particular product

rise above a competitive level, *id.* at 1285. *See also U.S. Healthcare,* 986 F.2d at 599 (the issue in determining whether HMOs constitute a separate market is "whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits").

Indeed, while broader markets might be relevant for some purposes, that does not preclude recognition of an HMO market in appropriate circumstances. For example, the evidence in a particular case might establish that some current HMO customers so strongly prefer HMOs that they would not switch to other delivery systems even if price were raised to a noncompetitive level. If those customers were sufficiently numerous that the HMOs could profitably raise prices despite the loss of other customers (who did not so strongly prefer HMOs) to competing delivery systems, HMOs could collectively exercise market power. Thus, while it may generally be true that at least some customers will regard some PPOs as acceptable substitutes for some HMOs, only a fact-specific analysis on a particular record can establish whether the challenged practices threaten to harm consumers in a relevant market.[1]

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[1] Similarly, in assessing the likelihood that providers of HMO services could exercise market power, it would not be appropriate for a court merely to assume that physicians will readily "shift from one type of service to another if a change in relative prices makes one type more lucrative than others" (slip op. 6). While some physicians who provide (or would be willing to provide) services through a PPO might join particular new HMOs if existing HMOs raised prices above a competitive level, other doctors might prefer not to assume the financial risks associated with HMO participation or might be unwilling to accept HMO-imposed constraints on their practice of medicine. Whether the possibility of physicians shifting among service delivery arrangements would significantly constrain the ability of HMOs to raise price is a factual question to be resolved on the record in individual cases.

The Court could avoid the risk of serious misinterpretation by modifying the opinion to emphasize that its conclusion that "Security is not a monopolist of HMO services because HMOs are not a market" (slip op. at 9) and its observations relating to the ability of HMOs to exercise market power were based on the record in this case and were not intended to foreclose the possibility of a different result on a different record. In particular, the Court should make clear that it did not reject the jury's finding of an HMO product market simply because HMOs face some competition, regardless of the likelihood that such competition will provide an effective constraint on the ability of HMOs to exercise market power.

2. *Most-Favored Nation Clauses.* As the Court observed, MFN clauses may serve legitimate purposes in particular circumstances, and we do not dispute the Court's conclusion that the record in this case does not establish per se illegal price-fixing. *See* slip op. at 16. We are concerned, however, that the Court's discussion may be misinterpreted as a holding that such clauses never violate the Sherman Act.

MFN clauses may raise serious concerns under the antitrust laws.[2] For example, among other situations, a court might be faced with evidence that a party with a significant degree of market power used an MFN clause to restrain competition or evidence that competing providers were using such clauses as a means of reducing competition. MFN clauses might cause providers to refuse to discount their fees to anyone, when the result of selective discounts would be a reduction in fees from a plan that provides a significant portion of their income.

[2] We do not read the First Circuit's decision in *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990), as establishing a rule of per se legality for that Circuit. It, too, addressed only the facts of a particular case.

They might also impede competition among plans by making it very difficult for new plans to obtain viable panels of providers. Indeed, the United States has challenged MFN clauses in agreements between major health care plans and participating health care providers as unreasonable restraints of trade in three recent cases. The consent decrees negotiated in these cases prohibit the defendants from entering into or enforcing such agreements. *United States v. Delta Dental Plan of Arizona, Inc.*, 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995), *see* 59 Fed. Reg. 47349 (Sept. 15, 1994); *United States v. Oregon Dental Service*, 1995-2 Trade Cas. ¶ 71,062 (N.D. Cal. 1995), *see* 60 Fed. Reg. 21218 (May 1, 1995); *United States v. Vision Service Plan*, No. 1:49CV02693 (D.D.C. complaint and proposed consent decree filed Dec. 15, 1994), *see* 60 Fed. Reg. 5210 (Jan. 26, 1995).

This case does not require the Court to anticipate the circumstances under which an MFN might be held to violate the Sherman Act. We are concerned, however, that the Court's description of MFN clauses as "standard devices by which buyers try to bargain for low prices" and "the sort of conduct that the antitrust laws seek to encourage" (slip op. at 16) may be misunderstood as a conclusion that they necessarily pass muster under the Sherman Act or that an intent "to minimize the cost" (*id.*) of physicians' services is necessarily determinative.[8] We urge the Court, therefore, to make clear that its ruling related to the particular clause in the particular circumstances at issue in this case and that other cases involving MFN clauses must be evaluated upon their own facts.

CONCLUSION

The United States and the Federal Trade Commission take no position on the ultimate question of the suffi-

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[8] *Compare U.S. Healthcare*, 986 F.2d at 596 (motive is important to the extent that it serves as "a guide to expected effects, but effects are still the central concern of the antitrust laws").

ciency of the evidence in this case. We urge the Court to grant rehearing, however, so that the panel may modify its opinion to leave no doubt (1) that whether HMOs constitute a separate market is a question of fact and that the Court's conclusions with respect to the sufficiency of the evidence in this case would not foreclose findings in other cases that HMOs constitute a relevant antitrust market, and (2) that its conclusion as to the MFN clauses in this case does not foreclose a different result on a different record.

Respectfully submitted.

ANNE K. BINGAMAN
Assistant Attorney General

JOEL I. KLEIN
Deputy Assistant Attorney General

/s/ Nancy C. Garrison
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STEPHEN CALKINS
General Counsel
Federal Trade Commission
Washington, D.C. 20580

October 2, 1995

APPENDIX E

[Filed Jan. 3, 1995]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-137-S

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN and
COMPCARE HEALTH SERVICES
INSURANCE CORPORATION,
Plaintiffs,

v.

THE MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF
WISCONSIN, INC.,
Defendants.

SPECIAL VERDICT

1. Have the plaintiffs established one or more of the following relevant product and geographical markets?

a) HMO Services?

ANSWER: Yes
(Yes or No)

b) Primary Care?

ANSWER: Yes
(Yes or No)

c) Pediatric Care?

ANSWER: Yes
(Yes or No)

d) One or More Specialty Care Markets?

ANSWER: Yes
(Yes or No)

IF YOU ANSWERED YES TO QUESTION 1, PROCEED TO QUESTION 2. OTHERWISE PROCEED TO QUESTION 6.

2. Do the defendants possess monopoly power in any relevant market you found to exist?

ANSWER: Yes
(Yes or No)

IF YOU ANSWERED YES TO QUESTION 2, PROCEED TO QUESTION 3. OTHERWISE PROCEED TO QUESTION 4.

3. Have the defendants engaged in anti-competitive conduct to obtain or maintain monopoly power in any relevant market in which defendants have monopoly power?

ANSWER: Yes
(Yes or No)

4. Have defendants attempted to monopolize in any relevant market in which they do not possess monopoly power?

ANSWER: Yes
(Yes or No)

5. Have defendants conspired to intentionally obtain or maintain monopoly power in any relevant market?

ANSWER: Yes
(Yes or No)

6. Have defendants entered into a contract, combination or conspiracy the purpose of which or predictable effect was to unreasonably restrain trade in any relevant market?

ANSWER: Yes
(Yes or No)

7. Have defendants contracted, combined or conspired with a competitor or potential competitor to do any of the following in any relevant market?
(Answer yes or no)

a) Allocate customers?	Yes
b) Allocate territories?	Yes
c) Allocate product or service markets?	Yes
d) Fix fees or prices	Yes

IF YOU ANSWERED YES TO ANY PART OF QUESTION 7, ANSWER QUESTION 8 AS TO THAT PART OF NUMBER 7 TO WHICH YOU ANSWERED YES, OTHERWISE PROCEED TO QUESTION 9.

8. Was the purpose or predictable effect to unreasonably restrain trade?

(Answer yes or no)

a) Allocate customers?	Yes
b) Allocate territories?	Yes
c) Allocate product or service markets?	Yes
d) Fix fees or prices	Yes

9. Did defendants violate section 133.04 of the Wisconsin Statutes?

ANSWER: Yes
(Yes or No)

Signed this 30th day of December, 1994.

/s/ James Byrnes
Foreperson

APPENDIX F

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

MOTION FILED
FEB 14 1996

(21)

No. 95-1118

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
AND
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

THE MARSHFIELD CLINIC
AND
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF BLUE CROSS AND BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Of Counsel:
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Dated: February 14, 1996

23 pp

No. 95-1118

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
AND
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

THE MARSHFIELD CLINIC
AND
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MOTION OF BLUE CROSS AND BLUE SHIELD ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Blue Cross and Blue Shield Association ("Association") respectfully moves, pursuant to Supreme Court Rule 37, for leave to file its brief as amicus curiae in support of the Petition for a Writ of Certiorari. The Association is an Illinois not-for-profit corporation. As the owner and licensor of the well-known Blue Cross® and Blue Shield® service marks for use by qualified health insurance plans and an active participant in America's health care delivery system, the Association has a vital interest in the competitive functioning of health care markets. The 67 independent Plans licensed by the Association provide prepaid, managed care

and other forms of health care financing to more than 65 million Americans. One in every four people in the United States with health insurance is covered by a licensed Plan. Petitioner Blue Cross & Blue Shield United of Wisconsin is the Association's licensee for the State of Wisconsin.

The Association's amicus brief brings a unique national and historical prospective to two issues presented by this case that are critical to competitive markets for the services of physicians and other health care providers in America:

> *First,* whether a dominant group medical practice like Respondent Marshfield Clinic may control the market price of physician services under the guise of a physician-controlled health care delivery system; and
>
> *Second,* whether such a dominant group medical practice may use most favored nation clauses to stabilize and inflate the market price of physician services.

In this case, a jury found that Respondent Marshfield Clinic used contracts with virtually every independent physician in North Central Wisconsin to fix and control the fees of these competing physicians in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§1-2. Among the instruments used by Respondent to control physician fees are most favored nation clauses. Although the trial court sustained the jury's verdict as supported by substantial record evidence, the Seventh Circuit reversed the price-fixing violations. That action profoundly threatens competition in provider markets, to the detriment of the Association, the Plans and other health insurers and purchasers of provider services. The Association's amicus brief explains from its unique prospective why the Court should grant the Petition for a Writ of Certiorari to examine these important issues and correct the errors of the Seventh Circuit.

The Association requested the consent of the parties to file its amicus brief. Respondents refused. Because the issues addressed by the Association's amicus brief are so important to the interests

of purchasers of physician services, like the 67 licensed Plans and the 65 million Americans they serve, the Association asks the Court to grant this motion and accept its amicus brief.

Respectfully submitted,

JACK A. ROVNER
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No. 95-1118

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
AND
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

THE MARSHFIELD CLINIC
AND
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

AMICUS CURIAE BRIEF OF BLUE CROSS AND BLUE SHIELD ASSOCIATION IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

INTEREST OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD ASSOCIATION

Blue Cross and Blue Shield Association ("Association") submits this amicus curiae brief in support of the Petition for a Writ of Certiorari of Blue Cross & Blue Shield United of Wisconsin ("Wisconsin Blue Cross"). The Association is an Illinois not-for-profit corporation that owns and licenses the Blue

Cross® and Blue Shield® service marks for use by qualified health insurance plans.[1] Wisconsin Blue Cross is the Association's licensee for the State of Wisconsin.

The 67 independent Plans licensed by the Association provide health insurance to more than 65 million Americans. They annually purchase tens of billions of dollars of health care services for these subscribers. To fulfill their missions as licensees of the Association to provide affordable health benefits to the nation's consumers, the Plans offer a variety of health care financing vehicles, including prepaid service benefits, indemnity insurance, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and point of service coverage ("POS"). Access to competitive health care provider markets is crucial to the economic viability of and consumer choice among these health care financing mechanisms. The Association and the licensed Plans therefore want and need competitive physician markets.

SUMMARY OF REASONS FOR GRANTING THE WRIT

The Writ should issue because the opinion of the Seventh Circuit in this case threatens competitive markets for physician services in at least two ways. First, the opinion appears to condone physician price-fixing when done under the guise of a physician-controlled health care delivery network. That is inconsistent with this Court's holding in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), and should be corrected. Second, the opinion appears to exonerate use of most favored nation clauses by physicians buying the services of competing providers, without regard to whether such competitors are using these arrangements to control price. That ignores the danger to price competition when competing physicians use these arrangements to buy from each other, as their incentives are to stabilize and inflate, not reduce, price.

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[1] A list of the licensed Plans appears in the Appendix to this brief.

REASONS FOR GRANTING THE WRIT

I. *The Seventh Circuit's Treatment of the Jury's Finding of Physician Price-Fixing and the Evidence that Sustained It.*

Respondent Marshfield Clinic is a group medical practice owned by the 400 physicians it employs. (Pet. App. 2a) It is the dominant provider of physician services in North Central Wisconsin. (Pet. App. 2a-3a, 7a) It owns the dominant HMO in North Central Wisconsin — Respondent Security Health Plan of Wisconsin, Inc. ("Security"). (Pet. App. 3a, 27a) Marshfield Clinic directly or through Security contracts with virtually every independent physician in North Central Wisconsin — nearly 900 otherwise competing physicians — to form a delivery network of physician services. (Pet. App. 3a; Tr. 746-50; Tr. Ex. 10222, 10344-52)

The jury found that these physician affiliation contracts are vehicles for Marshfield Clinic to fix and control the fees of the competing physicians in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2. (Pet. App. 76a) The trial court confirmed that the record evidence sustained the jury's finding: "There was evidence of price-fixing between Marshfield and its affiliated providers. The affiliated providers had only one fee schedule for both Security and non-Security patients, (Tr. at 887-889), and Marshfield approved or disapproved it. (Tr. 887-889.)" (Pet. App. 36a) The trial court observed that the combination of Marshfield Clinic and the 900 competing affiliated providers "is not a straight buyer-seller relationship, it is a relationship of competing sellers." (Pet. App. 36a) The result has been "supra-competitive prices and the elimination or reduction of competition" to the detriment of Wisconsin Blue Cross and other purchases of physician services in North Central Wisconsin. (Pet. App. 36a)

The Seventh Circuit brushed aside the jury's price-fixing verdict and the evidence supporting it with the bare statement that "[t]he only evidence of collusion is that the Clinic, when buying

services from the affiliated physicians either directly or through Security, would not pay them more than what these physicians charge their other patients." (Pet. App. 16a) The Seventh Circuit paid no attention to the evidence highlighted by the trial court "that price competition between the affiliates and Marshfield is controlled by Marshfield [which] obtains the fee schedules of its affiliates and approves or disapproves them." (Pet. App. 32a)[2]

Thus narrowing the issue to the legality of most favored nation clauses, despite the evidence of broader price control by Marshfield Clinic, the Seventh Circuit decreed that such clauses are "the sort of conduct that the antitrust laws seek to encourage" and "not price-fixing." (Pet. App. 17a) It made no effort to determine if the use of such clauses by physicians buying the services of competing physicians could serve as price stabilization mechanisms contrary to the interests of the ultimate purchasers of physician services, like the Association's licensed Plans.

II. *The Writ Should Issue to Affirm the Continued Application of* Maricopa *to Provider Price-Fixing Arrangements.*

The Seventh Circuit's rejection of the physician price-fixing found by the jury and sustained by the trial court is inconsistent with this Court's teachings in *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982). The Writ should issue to address and correct this inconsistency.

Maricopa presented the question whether "agreements among competing physicians setting, by majority vote, the maximum fees that they may claim in full payment for health services provided

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[2]This alone is sufficient reason for the Writ to issue. As it was reviewing a jury verdict, the Seventh Circuit was constitutionally bound by the jury's determinations as long as there is evidence in the record to support them. *Atlantic & Gulf Stevedores v. Ellerman Lines, Ltd.*, 369 U.S. 355, 358-59 (1962) ("neither we nor the Court of Appeals can redetermine facts found by the jury any more than the District Court can predetermine them"); *Tennant v. Peoria & Pekin Union Ry.*, 321 U.S. 29, 35 (1944) ("Courts are not free to reweigh the evidence and set aside the jury verdict merely because the jury could have drawn different inferences or conclusions, or because judges feel that other results are more reasonable").

to policyholders of specified insurance plans" violated *per se* Section 1 of the Sherman Act. 457 U.S. at 335-36. This Court answered with a definitive yes.

The parallels between the *Maricopa* facts and the facts of this case are striking. In *Maricopa,* about 70% of the competing physicians in two Arizona counties, by contracting with each other through "foundations for medical care," were able collectively to control their fees. 457 U.S. at 339-40. In this case, Marshfield Clinic — a physicians' group practice — by contracting directly or through its Security HMO with nearly every independent competing physician in North Central Wisconsin, is able to control the fees of those competing physicians. (Pet. App. 36a) In *Maricopa,* the physicians participating in the foundations had no financial interest in the foundations; the foundations were vehicles to sell their services at collectively fixed prices. 457 U.S. at 356. In this case, the independent physicians under contract with Marshfield Clinic or Security have no financial interest in either; the affiliation agreements are vehicles to sell their services to Marshfield Clinic and Security *and, critically,* for Marshfield Clinic to control the fees of these physicians generally. That is what the jury found and what the trial court confirmed that the evidence sustained. (Pet. App. 32a, 36a)

None of this was addressed by the Seventh Circuit before it decreed that Marshfield Clinic's activities are "not price-fixing." (Pet. App. 17a) Worse in this context, the Seventh Circuit's opinion appears to *encourage* the kind of illegal collusion found by the jury when it suggests that "[o]nly as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can [independent physicians] practice modern medicine in rural Wisconsin." (Pet. App. 10a)

The Seventh Circuit may have turned a blind eye to the antitrust dangers inherent in physician involvement in financing organizations, but the Association and the licensed Plans have not. In contrast to historical origins, each organization (including Wisconsin Blue Cross), in order to be licensed to use the Blue

Cross® and Blue Shield® service marks, now must not be controlled by any special interest group and must maintain a public majority on its governing board. These changes are consistent with the teachings of this Court, other Circuits and the federal antitrust enforcement agencies. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), this Court observed:

> "[E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally."

Cf. Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, 133 (1982) (Provider-controlled peer review panel used to review provider pricing carries "the potential to restrain competition").

Courts of the Second, Fourth, Fifth, Sixth and Ninth Circuits have warned of such dangers in permitting Sherman Act claims to proceed when providers dominate the fee-setting mechanisms. *E.g., Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980) (Requirement that psychologists bill through physicians to receive reimbursement from insurer an unreasonable trade restraint because the financing organizations "are combinations of physicians, operating under the direction and control of their physician members"), *cert. denied*, 450 U.S. 916 (1981); *St. Bernard General Hospital, Inc. v. Hospital Service Association of New Orleans, Inc.*, 712 F.2d 978 (5th Cir. 1983) (Reversing dismissal of price-fixing claims because, in part, "the participating hospitals enjoyed effective control of the Blue Cross board"), *cert. denied*, 466 U.S. 970 (1984); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of*

Michigan, Inc., 740 F.2d 423, 430 (6th Cir. 1984) (Reversing summary judgment for defendants with comment, "if Glen Eden is able to demonstrate control by other hospitals over the reimbursement payments Blue Cross is willing to offer it, the necessary agreement or conspiracy to fix prices of a competitor will be established"); *Hahn v. Oregon Physicians' Service*, 868 F.2d 1022 (9th Cir. 1988) (Reversing summary judgment for defendant because "whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors" is material fact issue), *cert. denied*, 493 U.S. 846 (1989); *Addino v. Genesee Valley Medical Care, Inc.*, 593 F. Supp. 892 (W.D.N.Y. 1984) (Summary judgment finding price-fixing because physicians "have the power to control the rate setting mechanism"). *See also Ratino v. Medical Service*, 718 F.2d 1260, 1270-71 (4th Cir. 1983) (dicta) ("If . . . in effect the physicians control the customary fee, under *Maricopa* [a court] must find such practice *per se* illegal").

The Department of Justice and Federal Trade Commission have also expressed concern about the risks to competitive pricing when, as was found in this case, independent providers collectively dominate provider pricing structures. *See, e.g.*, Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, *Statement 9 — Analytical Principles Relating to Multiprovider Networks* (Sept. 24, 1994).

The analysis in *St. Bernard Hospital* is particularly apt to the facts in this case. The price-fixing alleged in *St. Bernard Hospital* was an effort by the competing hospitals to control the pricing of other hospitals with which they competed. 712 F.2d at 987. That is precisely the conduct that the jury found Marshfield Clinic to have engaged in with respect to the competing affiliated physicians. According to the Fifth Circuit, that conduct is "a more egregious scheme of anticompetitive behavior than even *Maricopa*" because "[i]t imposes burdens on outsiders but not upon

the insiders who create the rules." *Id.* The Seventh Circuit's opinion ignores all these aspects of the Marshfield Clinic price-fixing found by the jury and sustained by the trial court on the evidence.

The continued evolution of efficient, cost-effective health care markets requires that courts stay vigilant against provider-controlled vehicles for fixing and controlling physician fees. The Seventh Circuit's opinion abandons that vigilance. This Court should grant the petition to reverse that mistake.

III. *The Writ Should Issue to Address the Proper Antitrust Treatment of Physician Use of Most Favored Nation Clauses in the Purchase of Competitors' Services.*

The Seventh Circuit's perfunctory approval of Marshfield Clinic's use of most favored nation clauses in the affiliated physician contracts failed to address the danger to competitive pricing such clauses pose when part of arrangements by which one group of physicians buys the services of competing physicians. This Court's insight in *Royal Drug* that, when providers control the reimbursement pricing, "there is little incentive . . . to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level," 440 U.S. at 232 n.40, fits precisely to this case. The facts of this case, thus, provide the ideal context for this Court to address and clarify the standards for determining the legality of most favored nation clauses under the Sherman Act.

The use of most favored nation clauses in health care markets has increasingly come under antitrust attack, and the question is ripe for this Court's review. When used by buyers, like the Association's licensed Plans which are not controlled by the providers whose services are being purchased, the courts have generally upheld these clauses as enhancing competition and consumer welfare; this has been the result even when such buyers are presumed to have monopsony power. *E.g., Ocean State Physicians Health Plan Inc. v. Blue Cross & Blue Shield of Rhode*

Island, 883 F.2d 1101, 1110 (1st Cir. 1989), *cert. denied,* 494 U.S. 1027 (1990); *Kipsap Physicians Service v. Washington Dental Service,* 671 F. Supp. 1267, 1269 (W.D. Wash. 1987); *Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cas. ¶ 63,351 (E.D. Mich. 1980); *Willamette Dental Group, P.C. v. Oregon Dental Service Corp.,* 130 Or. App. 487, 882 P.2d 637 (1994), *petition for review denied,* 320 Or. 508, 888 P.2d 569 (1995). *But cf. Reazin v. Blue Cross & Blue Shield of Kansas, Inc.,* 899 F.2d 951 (10th Cir.) (most favored nation clause considered "as evidence of, or as contributing to Blue Cross market or monopoly power," but "whether use of the most favored nations clause could itself violate section 2" not reached), *cert. denied,* 497 U.S. 1005 (1990). These decisions (except *Reazin*) are sound as a monopolist (or monopsonist) is entitled to compete, including obtaining the lowest prices possible from its suppliers to enhance its ability to do so. *See Ocean State Physicians Health Plan,* 883 F.2d at 1110 ("Section 2 does not prohibit vigorous competition on the part of a monopoly"); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.,* 784 F.2d 1325, 1339 (7th Cir. 1986) (rejecting argument that "firm with a large market share has an obligation not to augment that share at the expense of rivals" because "even a monopolist may bargain hard"); *Foremost Pro Color, Inc. v. Eastman Kodak Co.,* 703 F.2d 534, 544-46 (9th Cir.) ("monopolist, no less than any other competitor, is permitted and indeed encouraged to compete aggressively"), *cert. denied,* 465 U.S. 1038 (1984).

The current Department of Justice has undertaken to attack most favored nation clauses, whether used by provider-controlled or by independent health care buyers, on the premise that the clauses can be vehicles to stabilize price or bar competitive entry. *See, e.g., United States v. Delta Dental Plan of Arizona, Inc.,* 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995) (consent decree); *United States v. Oregon Dental Service,* 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D. Cal. 1995) (consent decree); *United States v. Vision Service Plan,* No. 1:49CV02693 (D.D.C.

Dec. 15, 1994) (complaint and proposed consent decree). Together with the Federal Trade Commission, the Department of Justice supported rehearing of the Seventh Circuit's decision in this case, *inter alia,* because of its concern that the opinion's exoneration of most favored nation clauses "may be misunderstood as a conclusion that they necessarily pass muster under the Sherman Act or that an intent 'to minimize the cost' [citation omitted] of physicians' services is necessarily determinative." (Pet. App. 72a).

The Association agrees that most favored nation clauses can interfere with price competition *when used by competing health care providers to buy each other's services,* as occurred in this case. In this case, the clause provided competing physicians with a powerful instrument for stabilizing and controlling physician prices generally in North Central Wisconsin. The jury found that Marshfield Clinic used the clause with that effect. That finding is consistent with the expectation noted by this Court in *Royal Drug*, 440 U.S. at 232 n.40, because Marshfield Clinic's incentives and that of each of the competing affiliated physicians that contracted with it are to maintain inflated prices, to the detriment of the ultimate purchasers like Wisconsin Blue Cross. *See* 6 Phillip E. Areeda, *Antitrust Law* § 1435e, at 229-31 (1986) (observing that most favored nation clauses used by competitors can "facilitate tacit price coordination"). The Seventh Circuit paid no heed to that circumstance. That is why the Association believes that the Seventh Circuit erred in its perfunctory approval of Marshfield Clinic's use of the clauses in its affiliation contracts with competing physicians.

On the other hand, the Association believes that the current Department of Justice has gone far beyond *that* danger to attack legitimate uses of the clause by health care buyers, like the licensed Plans, that are independent of the providers whose services they purchase. In doing so, the current Department of Justice has put itself at odds with *Ocean State Physicians Health Plan* and the other cases sustaining these clauses when used by

legitimate buyers, is interfering with the competitive workings of the negotiations between health care providers and buyers like the licensed Plans that are not provider controlled, and is encouraging providers to exercise their market power to price discriminate among buyers with impunity.

The Association urges that the Writ issue so that this Court may analyze and clarify the correct application of antitrust principles to most favored nation clauses. The Association believes that the Seventh Circuit had it wrong by being too narrow, while the current Department of Justice has it wrong by being too broad. By issuing the Writ in this case, this Court can set the correct parameters for analyzing the competitive effects of most favored nation clauses and help ensure that future courts, enforcement agencies and health care industry participants get it right.

CONCLUSION

Competition is forcing health care markets toward more efficient and cost-effective delivery mechanisms. Unfortunately, the Seventh Circuit's opinion in this case endangers the continuation of that competition by giving a wink to provider price-fixing that this Court held illegal *per se* in *Maricopa* and a nod to the inherent danger of provider use of most favored nation clauses in agreements with competing providers. The Writ should issue so that this Court can address and correct these critical errors that endanger consumer welfare and the competitive functioning of health care markets.

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Dated: February 14, 1996

APPENDIX

Licensed Plans of the Blue Cross and Blue Shield Association

ALABAMA	Blue Cross and Blue Shield of Alabama, Birmingham
ALASKA	Premera, Seattle
ARIZONA	Blue Cross and Blue Shield of Arizona, Inc., Phoenix
ARKANSAS	Arkansas Blue Cross and Blue Shield, Little Rock
CALIFORNIA	Blue Cross of California, Woodland Hills California Physicians' Service, San Francisco
COLORADO	Rocky Mountain Hospital and Medical Service, Denver
CONNECTICUT	Blue Cross & Blue Shield of Connecticut, Inc., North Haven
DELAWARE	Blue Cross & Blue Shield of Delaware, Inc., Wilmington
DISTRICT OF COLUMBIA	Group Hospitalization and Medical Services, Inc., Washington
FLORIDA	Blue Cross and Blue Shield of Florida, Inc., Jacksonville
GEORGIA	Blue Cross and Blue Shield of Georgia, Inc., Atlanta
HAWAII	Hawaii Medical Service Association, Honolulu
IDAHO	Blue Cross of Idaho Health Service, Inc., Boise Medical Service Bureau of Idaho, Inc., Lewiston
ILLINOIS	Health Care Service Corporation, a Mutual Legal Reserve Company, Chicago

INDIANA and KENTUCKY	Associated Insurance Companies, Inc., Indianapolis
IOWA	IASD Health Services Corp., Des Moines
KANSAS	Blue Cross and Blue Shield of Kansas, Inc., Topeka
LOUISIANA	Louisiana Health Service & Indemnity Company, Baton Rouge
MAINE	Associated Hospital Service of Maine, Portland
MARYLAND	Blue Cross and Blue Shield of Maryland, Inc., Baltimore
MASSACHUSETTS	Blue Cross and Blue Shield of Massachusetts, Inc., Boston
MICHIGAN	Blue Cross and Blue Shield of Michigan, Detroit
MINNESOTA	Aware Integrated, Inc., St. Paul
MISSISSIPPI	Blue Cross & Blue Shield of Mississippi, Inc., Jackson
MISSOURI	Blue Cross and Blue Shield of Kansas City, Kansas City Blue Cross and Blue Shield of Missouri, St. Louis
MONTANA	Blue Cross and Blue Shield of Montana, Inc., Helena
NEBRASKA	Blue Cross and Blue Shield of Nebraska, Omaha
NEVADA	Blue Cross and Blue Shield of Nevada, Reno
NEW HAMPSHIRE	New Hampshire-Vermont Health Service, Manchester
NEW JERSEY	Blue Cross and Blue Shield of New Jersey, Inc., Newark
NEW MEXICO	New Mexico Blue Cross & Blue Shield, Inc., Albuquerque

NEW YORK	Blue Cross and Blue Shield of Central New York, Inc., Syracuse
	Blue Cross and Blue Shield of Utica-Watertown, Inc., Watertown
	Blue Cross and Blue Shield of Western New York, Inc., Buffalo
	Empire Blue Cross and Blue Shield, New York City
	The Finger Lakes Companies, Inc., Rochester
NORTH CAROLINA ...	Blue Cross and Blue Shield of North Carolina, Durham
NORTH DAKOTA	Blue Cross Blue Shield of North Dakota, Fargo
OHIO	Blue Cross & Blue Shield Mutual of Ohio, Cleveland
	The Community Mutual Insurance Company, Cincinnati
OKLAHOMA	Group Health Service of Oklahoma, Inc., Tulsa
OREGON	Blue Cross and Blue Shield of Oregon, Portland
PENNSYLVANIA	Capital Blue Cross, Harrisburg
	Hospital Service Association of Northeastern Pennsylvania, Wilkes Barre
	Independence Blue Cross, Philadelphia
	Medical Service Association of Pennsylvania, Camp Hill
	Veritus, Inc., Pittsburgh
PUERTO RICO	La Cruz Azul de Puerto Rico, San Juan
	Seguros de Servicio de Salud de Puerto Rico, Inc., San Juan
RHODE ISLAND	Blue Cross & Blue Shield of Rhode Island, Providence
SOUTH CAROLINA ...	Blue Cross and Blue Shield of South Carolina, Columbia
SOUTH DAKOTA	South Dakota Medical Service, Inc., Sioux Falls

TENNESSEE	Blue Cross and Blue Shield of Tennessee, Chattanooga Memphis Hospital Service and Surgical Association, Inc., Memphis
TEXAS	Blue Cross and Blue Shield of Texas, Inc., Dallas
UTAH	Blue Cross and Blue Shield of Utah, Salt Lake City
VERMONT	Vermont Health Service Corporation, Montpelier
VIRGINIA	Blue Cross and Blue Shield of Virginia, Richmond
WASHINGTON	King County Medical Blue Shield, Seattle Pierce County Medical Bureau, Inc., Tacoma Premera, Seattle Washington Physicians Service, Inc., Seattle
WEST VIRGINIA	Mountain State Blue Cross & Blue Shield, Inc., Charleston
WISCONSIN	Blue Cross & Blue Shield United of Wisconsin, Milwaukee
WYOMING	Blue Cross and Blue Shield of Wyoming, Cheyenne

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No. 95-1118

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTIONS PRESENTED

1. Whether the court of appeals erred when it concluded that a jury's finding of an "HMO" product market was not reasonably supported by the evidence.

2. Whether the court of appeals erred when it concluded that a jury's finding that an HMO provider contract constituted price-fixing was not reasonably supported by the evidence.

PARTIES TO THE PROCEEDINGS

All parties in the courts below and here are listed in the caption. Respondent Marshfield Clinic is the corporate parent of respondent Security Health Plan of Wisconsin, Inc. Neither Marshfield nor Security has any partly owned subsidiaries.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-1118

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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RESPONDENTS' BRIEF IN OPPOSITION

INTRODUCTION

Neither repeated mischaracterization of the decision below nor the plain fabrication of "record" facts can mask the true nature of this petition: it seeks interlocutory review of nothing more than the sufficiency of evidence to support two "jury findings" (Pet. i) on essential elements of petitioners' antitrust claims. The petition thus raises no legal question at all: only whether the court of appeals erred in its application of record facts to settled (and here unchallenged) principles of law. Unable to cite a contrary holding of this Court or any other Circuit, petitioners must resort to criticizing the court of appeals

for secretly relying on "preconceived economic theories." Pet. 13. Yet it is they who invoke "[r]ecent scholarship" (Pet. 22) to launch an extended attack on the academic writings of Chief Judge Posner, the author of the unanimous opinion below. Petitioners' attack, however, ignores the decision itself, which by its terms is factbound; in fact, the decision expressly declares as to both questions presented here that another plaintiff on a different record might well succeed.

The petition also fails to disclose the alternative rulings that independently support the judgment below and would require affirmance no matter how the questions presented were decided. Thus, even if an "HMO" market had been proven, the circuit court's unchallenged conclusion that the *quality* of the Marshfield Clinic's physicians could not render it an "essential facility" would dispose of petitioner Compcare's claim for exclusion from the market. Even if the affiliation agreements between Marshfield's HMO and independent doctors were subject to attack for the use of "most favored nations" clauses, the circuit court's unchallenged rejection of the findings related to market definition and market power would dispose of petitioner Blue Cross's claim that the agreements unreasonably restrained trade.

Finally, the record on which petitioners base their request for review is so fundamentally deficient as to render this case a dismally inappropriate vehicle for thorough analysis of either question presented. In attempting to define an "HMO" market separate from other health insurance products, petitioners (1) were flatly contradicted by the testimony of their own expert economist, (2) repeatedly conceded that HMOs and other health plans "compete" for "the same prospects" (Tr. 631), and (3) failed to address the issue of supply substitution entirely.

Even worse, petitioners' argument on "most favored nations" clauses is based on a disturbing misrepresentation of the record. Seizing upon dicta in Chief Judge

Posner's opinion, petitioners contend for the first time in this Court that Marshfield's HMO provider contracts contain an actual " 'most favored nation' ('MFN') *clause.*" Pet. 4 (emphasis added). Not once during trial or on appeal did petitioners ever refer to MFN clauses, much less claim that the provider contracts contained them. As shown below, petitioners know that no such clause exists.

In sum, this record will support neither plaintiffs' position on the merits, nor the informed exploration of any issue related to HMO markets or MFNs.

STATEMENT

1. Respondent Marshfield Clinic, a medical clinic based in the city of Marshfield, Wisconsin, provides physician services to patients on a fee-for-service basis. Pet. App. 2a-3a. Marshfield employs about 400 primary care physicians and specialists at various clinics throughout mostly rural areas in northern and central Wisconsin. *Id.* Marshfield is, according to petitioners, "one of the most prominent medical clinics in the country." Tr. Ex. 304.

Respondent Security Health Plan of Wisconsin, Inc. ("Security"), a health maintenance organization ("HMO") owned and operated by Marshfield, provides pre-paid physician services at fixed monthly rates. To provide those services, Security contracts with Marshfield and with approximately 900 independent physicians known as "affiliates." Pet. App. 3a. The affiliated provider contracts are non-exclusive; affiliates may treat non-Security patients either on a fee-for-service basis, in competition with Marshfield, or through alternative HMO networks, in competition with Security. *Id.* Affiliates derive only a small percentage of their total income from treatment provided to Security patients. *Id.*[1]

[1] In addition to the evidence relied on by the court of appeals for this proposition (Pet. App. 65a), other unchallenged testimony confirms that affiliates derived only a small portion of their income

Petitioner Blue Cross & Blue Shield United of Wisconsin, an insurance company, sells indemnity health insurance to customers, many of whom purchase physician services from Marshfield. Pet. App. 13a-14a. Petitioner Compcare Health Services Insurance Corporation, a Blue Cross subsidiary, is an HMO that directly competes against Security. Pet. App. 2a.

2. On February 16, 1994, petitioners filed this antitrust action against respondents in the United States District Court for the Western District of Wisconsin. To prove their respective claims for monopolization, petitioners sought to define no fewer than 520 assertedly distinct physician services markets: 13 primary care markets, 13 pediatric care markets, and 494 specialty care markets. Pet. App. 8a-9a, 29a-30a, 61a. Petitioners urged at trial that Marshfield possessed monopoly or market power in "one or more" of each kind of market. Pet. App. 74a-75a.

Compare's monopolization claim was based on the "essential facilities" doctrine (Pet. App. 27a), which under limited circumstances may require a monopolist in an upstream market to sell goods or services "essential" to competition in a downstream market, *see, e.g., MCI Communications Co. v. AT&T*, 708 F.2d 1081, 1133 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983). Specifically, Compcare alleged that because Marshfield's physicians were the "best" in the area (Pet. App. 12a), it had an affirmative duty to sell physician services to Compcare, in order to assist Compcare in its competition against Security. Pet. App. 27a-28a.[2] As a result of Marshfield's

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from treating Security patients. Tr. 905 ("no more than five to eight percent"); Tr. 1735 ("5 percent or less"); Tr. 1773 ("[a]pproximately four percent").

[2] Although Compcare initially denied to the court of appeals that its essential facilities claim was based on the high quality of Marshfield, the record makes clear that it was. *E.g.*, Tr. 328 ("customers feel [Marshfield's] quality is best and they feel the service is best");

failure to do so—at least on terms demanded by petitioners—Compcare alleged that it had suffered an antitrust injury defined as "exclusion" from a putative "HMO services" market. Pet. App. 2a, 23a, 45a.

Blue Cross took a more blunderbuss approach, raising claims of monopolization, conspiracy and every other theory known to the Sherman Act, based upon virtually every major business decision made by Marshfield over the course of two decades. These included every one of its acquisitions of any clinic or physician practice and all of its employment contracts; these included the very existence of the HMO and the hundreds of affiliated provider contracts it entered into; these also included a variety of service contracts and joint ventures with at least six uncharged parties not involved in this litigation. Pet. App. 33a, 45a-53a. Blue Cross specifically challenged the affiliated provider contracts, by which Security contracted with physicians not employed by Marshfield, as "price-fixing." Pet. App. 36a. Blue Cross alleged that Marshfield, as a result of this various conduct, was able to charge "supracompetitive prices" to patients and thus increase Blue Cross's cost of performing under its indemnity contracts with those patients. Pet. App. 2a, 28a.

Tr. 616 ("From a consumer's standpoint it would be a better network if we had Marshfield Clinic."); Tr. 978 ("the best doctors in Central Wisconsin"); Tr. 1115 ("if quality is what the employer is looking for, you have to have that clinic"); Tr. 2403 (petitioners' final argument) ("Even if [other doctors] signed up with us, we couldn't get any business because we can't get the Marshfield Clinic. So it wouldn't make any difference.").

Petitioners subsequently conceded that this claim was based on quality: "This Court's determination, that the reputation for quality of defendants' physicians may not make them an essential facility (for the entry of a competing HMO), is both [sic] contrary to its own decision[s] . . ., and it conflicts with . . . *Eastman Kodak* . . . ." Appellees' Motion to Stay Mandate Pending Petition for Writ of Certiorari at 6-7 (Oct. 18, 1995).

The jury found for petitioners on all counts. Pet. App. 74a-75a. The jury awarded damages, before trebling, of $10.5 million to Blue Cross (Pet. App. 39a) and $5,669,277 to Compcare. Pet. App. 42a.

3. On post-trial motions, the district court upheld the jury's liability determinations in virtually all relevant respects. The court found (a) sufficient evidence to support, among other things, jury findings that Marshfield has monopoly power in "one or more" physician services markets for primary care, pediatric care, and specialty care (Pet. App. 29a-32a); (b) sufficient evidence of an "HMO services" market and an essential facilities violation (Pet. App. 23a-28a);[3] (c) sufficient evidence to conclude that the affiliated provider contracts constituted "price fixing" (Pet. App. 36a); and (d) sufficient evidence to conclude that Marshfield had engaged in several illegal conspiracies (Pet. App. 36a-37a, 47a-53a).[4]

Through a remittitur, the district court reduced by 65% the jury's damages awards, which it characterized as "monstrously excessive." Pet. App. 39a, 43a. The court reduced Blue Cross's untrebled award, which the jury had determined "[m]agically" (Pet. App. 38a), from $10.5 million to $594,833. Pet. App. 42a.[5] The court also re-

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[3] The district court recognized that Compcare could not prevail on any claim "[w]ithout an HMO market" and held further that Compcare had waived its "late attempts" to argue alternative theories. Pet. App. 23a. Compcare did not challenge either of these rulings on appeal.

[4] The court acknowledged that an "inconsistency" in its special verdict form foreclosed liability for attempted monopolization. Pet. App. 33a-34a. The court held, however, that the failure of that claim in no way restricted the remedies available to petitioners. Pet. App. 34a.

[5] During the damages trial, petitioners presented testimony that Blue Cross had suffered "overcharge" damages of approximately $594,000. Pet. App. 39a. The $10.5 million was a figure advocated only in closing argument by petitioners' counsel, who urged the jury to disregard the testimony of his own expert. Pet. App. 38a; Tr. 2834-35.

duced Compcare's untrebled award to $5,074,394, in order to offset the jury's multiple computational errors. Pet. App. 39a, 43a, 63a.

Finally, the district court granted petitioners a "sweeping" injunction (Pet. App. 2a) that, among other things, required Marshfield to sell physician services to Compcare on a "nondiscriminatory" basis (Pet. App. 58a), prohibited respondents from charging any "supra-competitive" prices (*id.*), and voided entire categories of respondents' business contracts (Pet. App. 55a-57a). The court of appeals stayed the injunction pending appeal. Pet. App. 2a.

4. The court of appeals unanimously affirmed in part, reversed in part, and remanded for further proceedings. In so doing, the court addressed only two questions that were purely legal: whether Blue Cross, as an indemnity insurer of Marshfield patients, has standing to sue Marshfield for alleged overcharges (Pet. App. 14a-15a); and whether the "superb" quality of Marshfield physician services could render them "essential" for purposes of the essential facilities doctrine (Pet. App. 12a). Every other issue resolved by the court of appeals, as petitioners now explain, involved challenges to the "sufficiency of the evidence." Pet. 7.

At the outset, the court held that Compcare had produced insufficient evidence to support the finding of a separate market for "HMO services." The court began by correctly stating its limited standard of review: "if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we think as an original matter." Pet. App. 3a. The court also correctly stated the applicable legal rule: "[i]n defining a market, one must consider substitution by buyers and by sellers." Pet. App. 5a (citing IIA P. Areeda, J. Solow & H. Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 530a (1995)). The court "searched the record in vain for evidence" of an "HMO

services" market. Pet. App. 3a. Having done so, it concluded: "We thus do not believe that a reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a separate market." Pet. App. 7a.

The court also held that, in all events, Marshfield had no affirmative obligation to deal with Compcare, because the high quality of Marshfield physician services (Pet. App. 12a) could not make those services "essential" for purposes of the essential facilities doctrine: "The suggestion that the price of being 'best' is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect." *Id.* That holding, dispositive of all of petitioner Compcare's claims, has not been challenged in this Court.

The court also addressed various issues involving market definition and power in the physician services markets alleged by petitioners. The court held that petitioners had produced insufficient evidence to prove any well-defined primary care markets (Pet. App. 7a-8a), pediatric care markets (*id.*), or specialty care markets (Pet. App. 8a). Even assuming proper markets, the court also held that petitioners had produced insufficient evidence that Marshfield has power in any physician services market. Pet. App. 7a-8a, 10a. Marshfield Clinic, the court concluded, "is not a monopolist." Pet. App. 10a. These holdings, dispositive of all of petitioners' claims (other than those based on *per se* theories of liability), have not been challenged in this Court.

The court also held that Blue Cross had produced insufficient evidence to support the jury's finding that Security's affiliated provider contracts constitute price fixing. Pet. App. 16a-17a. Petitioners had argued to the court of appeals that those agreements constitute "price fixing" because their "practical result" is "to establish a floor

for *all* of an affiliate's charges, *not* just charges to Marshfield." Appellees' Brief and Supplemental Appendix at 15 (July 20, 1995) ("Appellees' Br.").[6] Noting that the agreements themselves constituted "the only evidence of collusion" with the affiliates, and construing petitioners' argument to be that the agreements contained express MFN clauses, the court observed that such clauses are "not price-fixing." Pet. App. 17a.

> 'Most favored nations' clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the anti-trust laws seek to encourage. It is not price-fixing. [*Id.*]

Addressing the numerous contracts attacked by Blue Cross under a *per se* theory of market division, the court found "sufficient" (though "scanty") evidence of a single illegal agreement between Marshfield and the North Central Health Protection Plan, an uncharged third party, "not to open offices in each other's territories." Pet. App. 17a-18a. The court remanded the case to the district court for a determination of the Clayton Act damages, if any,

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[6] Petitioners addressed the affiliated provider contracts only in a section of their brief titled "Price Fixing," which argued as follows:

> The "Affiliated Provider Subcontract" . . . is not, as Marshfield states, a "buyer and seller setting a price." Affiliated physicians must submit to Marshfield a schedule of their "usual and customary charges" and their Marshfield payment is based on that schedule. Obviously, Marshfield does not wish to pay the affiliates more than the affiliates charge their non-enrollee patients, and *the practical result of the contracts* is to establish a floor for *all* of an affiliate's charges, *not* just charges to Marshfield. Thus, the physician's fee schedule subject to Marshfield's approval is the only one in effect for all of the physician's patients.

Appellees' Br. at 15 (first emphasis added) (citations omitted).

flowing to Blue Cross from that one agreement. Pet. App. 19a.

Finally, the court approved an injunction limited to the prohibition of market division agreements in the future. *Id.* The court vacated the entire injunction imposed by the district court, however, and it ordered any injunction on remand "to be rewritten from scratch." *Id.*

5. On rehearing in the court of appeals, the United States and the Federal Trade Commission filed a brief *amici curiae* that took "no position on the sufficiency of the record to support the jury's verdict," but expressed "concer[n]" that the court's opinion "may mislead readers unfamiliar with the record and arguments in this case." Pet. App. 68a. The government asserted that "the Court's statement that 'HMOs are not a market' . . . might be read *inappropriately* out of context, to establish a rule of general applicability." Pet. App. 69a (emphasis added). The government also expressed concern that the opinion "may be *misinterpreted* as a holding that [MFN] clauses never violate the Sherman Act," although it expressly agreed that "MFN clauses may serve legitimate purposes in particular circumstances," and did "*not* dispute the Court's conclusion that the record in this case does not establish per se illegal price fixing." Pet. App. 71a (emphases added). The government urged the panel to "modify its opinion" to "leave no doubt" on these issues. Pet. App. 73a.

Although the court had expressly tied its holding to the record in several places, it nonetheless obliged. After its statement that no "reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a separate market" (Pet. App. 7a), the court added another sentence repeating itself: "We emphasize 'record compiled in the district court.'" Pet. App. 65a. With regard to its statement that MFN clauses are "not price-fixing" (Pet. App. 17a), the court added a sentence

explaining: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case." Pet. App. 65a.

REASONS FOR DENYING THE WRIT

The petition for certiorari is insubstantial if not frivolous. On its face, the petition raises no legal question for this Court's review, but simply challenges two sufficiency determinations that the court of appeals explicitly limited to the record in this case. Moreover, the petition fails to challenge several additional holdings that independently support all portions of the judgment challenged here by petitioners. Finally, even assuming that petitioners' sufficiency claims would otherwise warrant review, they are meritless in any event.

I. PETITIONERS RAISE NO LEGAL QUESTION FOR THIS COURT'S REVIEW

The questions presented, stripped of their lengthy and conclusory summations of purported evidence, seek review of whether the court of appeals incorrectly overturned jury factfinding. Question 1 asks this Court to determine whether the court of appeals "correctly overturned a jury finding" that "HMO services" constitute a separate product market. Pet. i. Similarly, Question 2 seeks review of whether, in light of the supposed MFN clauses, the court of appeals "correctly overturned jury findings" of monopolization and conspiracy. *Id.* This Court, however, "do[es] not grant a certiorari to review evidence and discuss specific facts." *United States v. Johnston*, 268 U.S. 220, 227 (1925). *See, e.g., NLRB v. Hendricks County Rural Electric Membership Corp.*, 454 U.S. 170, 176 n.8 (1981); R. Stern, E. Gressman, S. Shapiro, K. Geller, *Supreme Court Practice* § 4.14, at 189-90 (7th ed. 1993).

The body of the petition fares no better. With regard to the alleged "HMO services" market, petitioners do not

seriously take issue with the court of appeals' statement that market definition ultimately turns on "substitution both by buyers and sellers" (Pet. App. 5a). As this Court has long held, a proper antitrust market " 'is composed of products that have reasonable interchangeability.' " *Eastman Kodak Co. v. Image Technical Serv. Inc.*, 504 U.S. 451, 481 (1992) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956)). In a single footnote, petitioners briefly suggest that the "practical indicia" set forth in *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962), supply a different legal standard. Pet. 14 n.10. *Brown Shoe* itself, however, made clear that the relevant market "must be drawn with sufficient breadth to include the competing products." 370 U.S. at 326. Thus, the courts of appeals have recognized that *Brown Shoe*'s "practical indicia" are merely "evidentiary proxies for direct proof of substitutability." *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210, 218 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987).[7] Petitioners' own authority makes this clear. *See, e.g., U.S. Anchor Mfg., Inc. v. Rule Indus., Inc.*, 7 F.3d 986, 995 (11th Cir. 1993) ("practical indicia" are "equivalent" to substitutability), *cert. denied*, 114 S. Ct. 2710 (1994); *H.J., Inc. v. ITT Corp.*, 867 F.2d 1531, 1540 (8th Cir. 1989) (quoting *Rothery*).

Petitioners also fail to identify any legal controversy (much less a circuit split) regarding the application of these principles in the specific context of alleged markets for "HMO services." On the contrary, petitioners concede that the definition of particular markets "is an intensely fact-based undertaking." Pet. 13. Moreover, petitioners do not cite even a single case where a plaintiff has successfully proven an "HMO services" market, and

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[7] *Accord, e.g., White & White, Inc. v. American Hosp. Supply Corp.*, 723 F.2d 495, 502 (6th Cir. 1983); *Thurman Indus. Inc. v. Pay 'N Pak Stores, Inc.*, 875 F.2d 1369, 1375-77 (9th Cir. 1989); II P. Areeda & D. Turner, *Antitrust Law* ¶ 535b, at 419-21 (1978).

they ignore several decisions finding legally insufficient proof of an "HMO services" market narrow enough to exclude all alternative forms of health insurance. *See Hassan v. Independent Practice Assocs., P.C.*, 698 F. Supp. 679, 695 n.47 (E.D. Mich. 1988) (granting summary judgment); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 692 F. Supp. 52, 68 (D.R.I. 1988) (granting JNOV), *aff'd*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); *National Benefit Administrators v. Blue Cross & Blue Shield of Alabama*, 1989-2 Trade Cas. (CCH) ¶ 68,831, 62,372 (M.D. Ala. 1989) (granting summary judgment), *aff'd without op.*, 906 F.2d 1143 (11th Cir. 1990).[8]

Petitioners also raise no legal question regarding the alleged MFN clause in the affiliated provider contracts. Petitioners do not, and could not, seek to extend to MFN classes the *per se* rule—which is limited to discrete categories of agreements that are " 'always or almost always' " anticompetitive, *Northwest Wholesale Stationers v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 289-90 (1985) (citation omitted). As the government noted in the court of appeals, "MFN clauses may serve legitimate purposes in particular circumstances." Pet. App. 71a.[9] Indeed, petitioners made a similar argument to the district court

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[8] In the only HMO decision cited by petitioners (Pet. 14), a magistrate judge rejected an alleged "HMO services" market as a factual matter, and the First Circuit affirmed. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 598-99 (1st Cir. 1993). *See also Ball Memorial Hosp. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1331 (7th Cir. 1986) (also affirming rejection of alleged "HMO services" market).

[9] *See also Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1110 (1st Cir. 1989) (MFN clause "tends to further competition on the merits"), *cert. denied*, 494 U.S. 1027 (1990); *Associated Milk Dealers, Inc. v. Milk Drivers Union, Local 753*, 422 F.2d 546, 554 (7th Cir. 1970) (MFN clause not subject to *per se* rule).

when they sought to include in the injunctive order an MFN clause in favor of *themselves*. MFN clauses, they argued, "have been enthusiastically approved by courts that have addressed them since such clauses *increase* price competition." Plaintiffs' Reply Brief in Support of Motion for Entry of an Order for Declaratory and Injunctive Relief at 102 (Feb. 21, 1995) (emphasis in original). Nor do petitioners identify any legal question regarding either the rule of reason or its application in the specific context of MFN clauses.

Instead, petitioners attempt to mischaracterize the grounds of the court of appeals' decision. Petitioners contend that the decision rests on "economic generalizations rather than record evidence" (Pet. 10); that "nothing in the court's analysis" is "limited to a particular time, place, or trial record" (*id.*); that the court "generally endorsed MFN clauses" (Pet. 20); and that other courts, in future cases, will have no "basis for distinguishing" the court's holdings (Pet. 12). Petitioners seek to buttress these characterizations with extended criticism (Pet. 18-23) of the academic writings of Chief Judge Posner and Judge Easterbrook (who was not on the panel below), and with the astonishing suggestion that because Chief Judge Posner has displayed "facility with economic analysis" (Pet. 8) his decision for a unanimous panel must reflect "dogmatic generalizations based on preconceived economic theories" (Pet. 13).

Petitioners' charges are meritless. Petitioners ignore the fact that the appeal below, in their own words, raised only "sufficiency of the evidence" challenges. Pet. 7. More importantly, petitioners ignore what the court of appeals actually said. With respect to the alleged "HMO services" market, the court noted that "if there is a reasonable basis for this finding in the evidence, we are bound to accept it." Pet. App. 3a. After concluding that no "reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a sep-

arate market" (Pet. App. 7a), the court granted the government's request that it "leave no doubt" (Pet. App. 73a): "We emphasize 'record compiled in the district court.'" Pet. App. 65a. Similarly, with respect to the alleged MFN clause, the court stated explicitly that such clauses might be "misused to anticompetitive ends" in other cases, but that "there is no evidence of that in this case." *Id.*

Ultimately, petitioners are left to complain that the decision below, limited by its terms to the trial record, is not larded with "citation" to specific pages in "the trial record." Pet. 11. Leaving to one side the pointlessness of citing the record for a *lack* of evidence, this Court's job "'is to review judgments, not to edit opinions.'" *Powell v. Nevada*, 114 S. Ct. 1280, 1285 (1994) (Thomas J., dissenting) (quoting *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 823 (1985) (Stevens, J., concurring in part and dissenting in part)).[10]

Because petitioners raise only sufficiency challenges, and have identified no legal issue for this Court's review, the Court should deny their petition.

II. PETITIONERS FAIL TO CHALLENGE ALTERNATIVE HOLDINGS THAT INDEPENDENTLY SUPPORT THE DECISION BELOW

Even assuming that petitioners' two sufficiency claims would otherwise warrant review, petitioners fail to chal-

[10] Equally insubstantial is petitioners' argument (Pet. 28-29) that *amicus* participation and media coverage of this case below somehow establish the importance of the sufficiency questions raised in their petition to this Court. Only one *amicus* supported petitioners, addressing only a single question: the standing of a purchaser's indemnity insurer to raise antitrust claims against the seller. The media coverage, moreover, was a result of "the prominence of the featured players and the dollar value of the jury verdicts," B. Clay & M. LaFond, *Antitrust and Integrated Delivery Systems*, Health L. Dig., Feb. 1995, at 9, not the sufficiency issues in a particular antitrust case.

lenge several additional holdings by the court of appeals that independently support its judgment.

Most significantly, petitioners do not challenge the court of appeals' critical holdings with respect to market definition and power in the various alleged physician services markets. First, the court of appeals found petitioners' "dizzying series of concentric circles" insufficient to establish plausible geographic markets for primary and pediatric care. Pet. App. 8a.[11] Second, the court of appeals held that petitioners did not establish separate specialty care markets corresponding to each of 494 diagnostic related groups. Pet. App. 8a.[12] Third, the court of appeals held that petitioners in all events did not establish monopoly or market power in any physician services market. Pet. App. 7a-8a, 9a.[13] Petitioners do not, and could not, challenge any of these rulings.

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[11] At trial, petitioners' economist drew circles of approximately 30 to 50 miles around 13 Marshfield offices. Pet. App. 61a. He testified that *each circle* constituted a separate primary care and pediatric care market (Pet. App. 23a)—even though some circles are entirely contained within others and even though some areas are encompassed within no fewer than six different circles.

[12] As the court of appeals explained, DRGs, which were developed as a system for classifying the expected cost of hospital charges, *see, e.g., West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11, 15-16 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991), are "unrelated to the conditions of supply." Pet. App. 8a. Petitioners' unprecedented use of DRGs to define specialty care markets would have produced absurd consequences such as distinct antitrust markets for "circumcision of a male 17 years or older" and "circumcision of a male under 17." *Id.*

[13] To allege shares that could support an inference of market power, petitioners were forced to attribute to Marshfield *all* treatment rendered by the 900 Security affiliates (Pet. App. 3a, 31a-32a), even though the affiliates derive only a small fraction of their total income from their non-exclusive contracts with Security (Pet. App. 3a, 7a, 65a). Petitioners also were forced to assert, as they continue to do, that Marshfield prices "exceed statewide averages by 30%." Pet. 3 n.3. But as the court of appeals explained, higher than average prices cannot support an inference

The absence of any physician services markets in which Marshfield has power, which is now the law of this case, independently forecloses all claims that petitioners seek to raise here. First, to establish liability based on Marshfield's unilateral refusal to sell physician services to Compcare—under the essential facilities doctrine or otherwise —Compcare must show, at a minimum, that Marshfield has monopoly power in well-defined physician services markets. *See, e.g., Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 600-03 (1985); *MCI Communications Co. v. AT&T*, 708 F.2d 1081, 1133 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983). Regardless of what this Court might say about the alleged "HMO services" market, Compcare's claim is foreclosed by the court of appeals' unchallenged holding that Marshfield "is not a monopolist" in any physician services market. Pet. App. 10a.

Second, the court's holdings as to physician services markets also foreclose Blue Cross's conspiracy claim based on the alleged MFN clauses. As noted above, Blue Cross challenges the use of an alleged MFN clause only under the Rule of Reason—which requires a showing of markets, power, and specific anticompetitive impacts. *See, e.g., Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 45 (1977); *Illinois Corp. Travel, Inc. v. American Airlines, Inc.*, 806 F.2d 722, 727 (7th Cir. 1986). Regardless of what this Court might say about MFN clauses generally, Blue Cross cannot establish that Marshfield committed any rule of reason violation here, where the court of appeals' holdings as to physician services markets remain unchallenged.

Finally, Compcare's essential facilities claim fails on yet another independent and unchallenged holding below:

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of market power here, where petitioners not only concede Marshfield's "superb" quality (Pet. App. 12a), but use that quality as the basis for Compcare's essential facilities claim. Pet. App. 9a ("Generally you must pay more for higher quality.").

that regardless of any question about market power, Marshfield Clinic's "reputation for high quality" could not render Marshfield physician services "essential" for purposes of the essential facilities doctrine, because "the price of being 'best' is [not] to be . . . stripped of your power to decide whom to do business with . . . ." Pet. App. 12a.

This Court should reject petitioners' invitation not only to make sufficiency determinations, but to do so on issues that cannot possibly affect the ultimate outcome of the case.

III. PETITIONERS' SUFFICIENCY CLAIMS LACK MERIT

Beyond their other fatal difficulties, petitioners' sufficiency claims are also meritless. Indeed, the record is so deficient on these issues that it would frustrate any attempt at thorough consideration by this Court of any question presented.

A. Petitioners Failed To Prove An "HMO Services" Market

The record below makes clear that HMO products are reasonably interchangeable with, and face substantial competition from, other forms of health insurance or health care financing products, including preferred provider organizations ("PPOs") and traditional indemnity products such as those sold by Blue Cross.

Petitioners' own documents proved the point. A Blue Cross securities filing states that Compcare "face[s] substantial competition from other HMOs, PPOs, self-funded plans, the Parent [*i.e.*, Blue Cross] and indemnity insurance carriers." Tr. Ex. 236 at 18. A Blue Cross research memorandum notes that PPOs are "prime competition for HMOs." Tr. Ex. 335 at 5. And a Blue Cross marketing plan lists "competition" as including indemnity, HMO, PPO, and other plans. Tr. Ex. 337 at

025571-73. Petitioners made no effort to qualify or contradict these or a dozen similar statements.

Petitioners' own economists proved the point. Their principal expert testified flatly that the relevant market in which Compcare competes is "health care financing." Tr. 788. Their damages expert testified that switching between HMO and indemnity products "happens periodically throughout the health care financing market." Tr. 2612. Neither one asserted a separate "HMO services" market. Respondents' economist made it unanimous, testifying that there was no relevant "HMO" market, but only a "health care financing" market. Tr. 2059-64.

Petitioners' own executives proved the point. A Blue Cross vice president testified that "Compcare competes with the parent company Blue Cross." Tr. 81. A Blue Cross sales director testified that Security is a "major competitor" of Blue Cross. Tr. 680. Several large employers also acknowledged interchangeability among HMOs and other forms of health care financing. Tr. 2061-62. Indeed, as petitioners' own evidence showed, the City of Marshfield itself switched from Security's HMO product to Blue Cross's indemnity product. Tr. Ex. 1991.

Petitioners offered no evidence indicating that consumers do *not* regard HMOs and other health plans as interchangeable. After petitioner's economist conceded that Compcare competes in the "health care financing" market, petitioners offered the "expert" opinion of Jeffrey Nohl, Compcare's own President. Mr. Nohl acknowledged that patients switch between HMO and indemnity products (Tr. 1144-45), but nonetheless opined that "HMO products" constitute a separate product market because of their "distinct characteristics" from indemnity products (Pet. App. 24a). Under that reasoning, Mr. Nohl agreed that there would exist a separate product market for "Buicks." Tr. 1147. That is not the law. While "distinct characteristics" have evidentiary significance in determining substitutability, *see Brown Shoe*, 370 U.S. at 325-26;

Rothery, 792 F.2d at 218, they cannot establish a separate product market where, as here, reasonable substitutability and substantial competition are undisputed. *See, e.g., United States v. Continental Can Co.*, 378 U.S. 441, 449 (1964) (metal and glass containers occupy single product market because of "admitted competition"); *du Pont*, 351 U.S. at 399 (no separate product market for cellophane because, despite "advantages," it "has to meet competition from other materials"); *Packard Motor Car Co. v. Webster Motor Car Co.*, 243 F.2d 418, 420 (D.C. Cir.) (no separate product market for Packards), *cert. denied*, 355 U.S. 822 (1957). On the controlling issue —substitutability—the record below fully supports the court of appeals' decision.[14]

B. The Affiliated Provider Contracts Contain No MFN Clause

Petitioners' second question presented, although convoluted, focuses primarily on an alleged MFN clause in the Security provider contracts. Pet. i (contracts "required" affiliates "to reduce their lucrative compensation from the dominant HMO if they accepted lower offers from another HMO"); Pet. 19-20 (discussing "MFN clauses"). Nowhere in the proceedings below, however, did petitioners suggest that the provider contracts even contain an MFN clause, much less one that unreasonably

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[14] Nor do petitioners make any pretense of having addressed the issue of supply substitution—that is, the ability of other physician groups or network-based health plans to convert to HMOs if it were profitable to do so. This is especially critical on a record such as this, where petitioners themselves operated PPOs and point-of-service plans in the same geographic area alleged to be monopolized by Marshfield's HMO. Pet. App. 6a. In this Court, petitioners now speculate on differences between PPOs and HMOs that might inhibit supply substitution. Pet. 17 n.15. They conveniently ignore the POS plan network, which is indistinguishable from an HMO network. Tr. 332, 344, 1125. But it was petitioners' burden to prove the relevant market at trial and to cite record evidence in the court of appeals. Speculation outside the record on a petition for certiorari will not do.

restrains trade. Indeed, the *only* mention of MFNs in the record below (Tr. 2926-27) involved Blue Cross's attempt to secure *for itself* an MFN clause by injunction. The MFN issue simply never arose until the court of appeals, charitably construing petitioners' argument about *per se* price fixing, created for petitioners an alternative argument that, in fact, petitioners themselves had never made. Pet. App. 16a-17a.

Emboldened by that assistance, petitioners now contend that the affiliated provider contracts state that affiliates "will be compensated for services provided for Security subscribers *at their usual fee rates*—so long as the affiliated physicians further agree to a 'most favored nation' ('MFN') clause *preventing* them from receiving *less* from any other patient or health plan." Pet. 4 (second emphasis added). In fact, however, the contracts say something very different:

> *Professional Fee.* Subject to the limitations outlined below, Clinic agrees to reimburse the Affiliated Provider(s) at a rate of eighty-five (85%) of the lesser of Provider's usual and customary charges and Plan's maximum allowable charge for covered care that is rendered to eligible Participants in Plan except as outlined below in Plan's Prepaid Medicare Program. This section is effective on October 1, 1989, the beginning of Plan's current fiscal year.

Opp. App. 1a (Tr. Ex. 1444).[15] This is the very language cited by petitioners to the court of appeals when it argued that the "practical result" of the agreements created a price "floor." Appellees' Br. at 15. As this language shows, these contracts do not reimburse affiliates at 100% of their "unusal" fee rates, as petitioners now contend, but at 85% of that rate—a 15% discount. More importantly, the contracts do not prevent affiliates

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[15] "Opp. App." refers to the appendix to this brief in opposition.

from charging *less* to other purchasers, either explicitly or in practical effect, since affiliates' compensation from Security is a function not of the *lowest* rate charged to any other purchasers, as an actual MFN clause would provide, but of the *usual* rate charged to most other purchasers. Moreover, anticompetitive impacts are particularly implausible here, where affiliates receive only a small portion of their income from Security. Pet. App. 3a. Finally, respondents presented uncontroverted testimony, from several affiliates themselves, that their contractual relationships with Security played "no role at all" (Tr. 1752) or "absolutely none whatsoever" (Tr. 1537) in determining the price to charge non-Security patients.[16]

Petitioners made no effort to show what the prices charged by the affiliates to other purchasers actually were. This failure is especially telling, because data showing the prices these affiliates charge to their Blue Cross-insured patients was plainly available to petitioners. Given these lapses in genuine proof, petitioners' extended frolic (Pet. 18-23) through "Post Chicago" literature in general, and MFN literature in particular, does not even begin to explain how the provider contracts at issue in this record could or did restrain trade unreasonably.

The record available in this case is desperately inadequate for the intelligent analysis of any issue of "HMO" market definition or MFNs. This Court would be ill-served to take a market definition case in which the most fundamental evidence of interchangeability is missing and the issue of supply substitution is ignored—in which the plaintiff's purported market definition is refuted by its own economist. This Court would be deeply frustrated to take

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[16] Petitioners also repeatedly make the unsupported assertion that the affiliated provider agreements are also "*de facto* exclusive contracts." *E.g.*, Pet. 9. To the contrary, the again-uncontroverted evidence showed that Security affiliates do contract with competing health plans, including Compcare and Valley Health Plan, another Blue Cross HMO. Tr. 1733-34, 1751-52, 1770-72.

a case to consider the actual operation and effect of "most favored nations" clauses in the healthcare industry, only to find that the contracts in question do not have them.

CONCLUSION

The petition for a writ of certiorari should be denied.

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APPENDIX

APPENDIX

AFFILIATED PROVIDER SUBCONTRACT

THIS AGREEMENT, is made this —— day of ——-———, 19—, by and between MARSHFIELD CLINIC, a Wisconsin not-for-profit corporation engaged in the business of providing medical services, hereinafter referred to as "Clinic," and ————————————, a/an ————————————, by profession, hereinafter referred to as "Affiliated Provider(s)".

* * * *

PART III—BILLINGS AND COMPENSATION

3.01 *Professional Fee.* Subject to the limitations outlined below, Clinic agrees to reimburse the Affiliated Provider(s) at a rate of eighty-five (85%) of the lesser of Provider's usual and customary charges and Plan's maximum allowable charge for covered care that is rendered to eligible Participants in Plan except as outlined below in Plan's Prepaid Mediiare Program. This section is effective on October 1, 1989, the beginning of Plan's current fiscal year.

* * * *

3.06 *Notice of Charges.* Affiliated Provider(s) agrees (agree) to provide Plan's Insurance Committee with a schedule of his/her(their) usual and customary charges and further agrees(agree) to notify the Committee at least ninety (90) days in advance of the calendar year, i.e. by October 1, of any anticipated modifications in this schedule, which charges may then be recognized in the new calendar year, i.e. January 1. It is understood that additional changes in Affiliated Providers fee schedules will not be recognized by Plan during the fiscal year.

* * * *

No. 95-1118

In The
Supreme Court of the United States
October Term, 1995

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN and COMPCARE
HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY
HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

BRIEF OF AMICUS CURIAE STATES OF WISCONSIN, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, ILLINOIS, IOWA, KENTUCKY, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSOURI, NEVADA, NEW HAMPSHIRE, NEW MEXICO, NEW YORK, NORTH DAKOTA, OHIO, OREGON, PENNSYLVANIA, RHODE ISLAND, TEXAS, WASHINGTON AND WEST VIRGINIA IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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No. 95-1118

In The

Supreme Court of the United States

October Term, 1995

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN and COMPCARE
HEALTH SERVICES INSURANCE CORPORATION,

Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY
HEALTH PLAN OF WISCONSIN, INC.,

Respondents.

BRIEF OF AMICUS CURIAE IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

The States of Wisconsin, Arizona, Arkansas, Delaware, Florida, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Washington, and West Virginia (hereinafter "Amici States") submit this brief in support of the plaintiff's petition for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Seventh Circuit in *Blue Cross & Blue Shield United of Wisconsin and Compcare Health*

Services Insurance Corp. v. Marshfield Clinic and Security Health Plan of Wisconsin, Inc. (hereinafter *Blue Cross*), 65 F.3d 1406 (7th Cir. 1995), *rev'g*, 883 F. Supp. 1247 (W.D. Wis. 1995).[1] Review is warranted because the decision of the Seventh Circuit panel defines health care markets and applies the rule of reason in a manner which "conflicts with applicable decisions of this Court," Sup. Ct. R. 10(c), and which will undermine state antitrust enforcement in health care markets.

INTEREST OF THE AMICI STATES

As the chief law officers of their states, attorneys general are the primary public enforcers of the state antitrust laws, which are often required to be interpreted in conformity with federal law.[2] Both because these markets are generally

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[1] Citations to these decisions herein will refer to copies of the decisions contained in Appendix A attached to the Petition for Writ of Certiorari ("Pet. App.") submitted by petitioner. Consistent with Sup. Ct. R. 37.1, the Amici States subscribe to the arguments presented in the Petition and will not repeat those arguments herein.

[2] *E.g.*, *Carl N. Swenson Co., Inc. v. E.C. Braun Co.*, 272 Cal. App.2d 366, 77 Cal. Rep. 378, 379-80 (1969); *Grillo v. Board of Realtors*, 91 N.J. Super. 202, 219 A.2d 635 (1966); *State v. Milwaukee Braves, Inc.*, 31 Wis. 2d 699, 144 N.W.2d 1 (1966). *See also* Mont. Code Ann. § 30-14-104 (1989); Utah Code Ann. § 76-10-926 (1991); Wash. Rev. Code 19.86.920. The attorneys general also represent their states and political subdivisions in federal antitrust actions for damages and injunctive relief. In their capacity as *parens patriae*, they are authorized to bring federal antitrust actions on behalf of the citizens of their states. 15 U.S.C. § 15(c) (1989); *State of Georgia v. Pennsylvania R.R.*, 324 U.S. 439 (1945) (common law *parens patriae*); *Hawaii v. Standard Oil Company of California*, 405 U.S. 251 (1972).

local, and because HMOs and other types of health care arrangements are growing rapidly, the Amici States have a vital interest in preventing the evisceration of the antitrust laws as applied to health care markets. *See, e.g., Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). Indeed, HMOs have grown extremely rapidly to where HMO enrollment is projected to near 65 million Americans in 1996, up more than twenty-five percent since January, 1995.[3] Moreover, this membership surge, according to the newsletter of the American Medical Association, "will intensify price competition among HMOs, which are now more likely to battle each other--not higher-priced indemnity plans--for enrollees."[4]

The facts found by the jury, and concurred in by the trial judge, include a wide variety of monopolistic and conspiratorial acts that accomplished respondent Marshfield's goal of squelching HMO competition in north central Wisconsin (Pet. App. 32a-37a). Unless such conduct is carefully analyzed in the context of real product markets and then distinguished from aggressive, but legitimate, competition, the states will encounter great difficulty in maintaining competitive health care markets.

The Amici States are keenly disappointed that the court of appeals did not analyze the evidence in this case in a manner consistent with this Court's antitrust decisional law. If left standing, the decision will likely constitute a significant barrier to effective state antitrust enforcement in health care

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[3] Julie Johnsson, "HMOs Dominate, Shape the Market," Am. Med. News, January 22/29, 1996, at 1.

[4] *Id.*

markets. The decision will certainly encourage the rapid consolidation of HMOs, which state antitrust enforcers will be largely powerless to stop. Also, the approval by the court of appeals of a host of anticompetitive acts and agreements between Marshfield and independent doctors will undercut recent state and federal enforcement efforts.[5]

In addition, the Amici States have an even more particularized interest in the effective implementation of state policies designed to encourage the growth of HMO insurance products in competitive markets. For example, in the early 1980's, Wisconsin, like many other states, attempted to create a legal and economic environment that would encourage the growth of HMOs and would encourage competition among those HMOs.[6] Unfortunately, the benefits of these changes

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[5] *See, e.g., United States and State of Arizona v. Delta Dental Plan of Arizona, Inc.* 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995). The gravamen of the complaints was that Delta Dental engaged in price-fixing through the mechanism of most favored nation provisions in its contracts with plan dentists. The *Delta* case identified significant consumer demand for a discounted dental plan product wholly separate from existing insurance products. The settlement prohibits use of MFNs and discrimination against any dentist who offers discounted services.

[6] As discussed in Section I(B), below, the states have created distinct regulatory requirements for HMOs. *See* Jon B. Christianson, et al., *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991) (forty-six states have explicit HMO legislation). Moreover, states such as Arizona have operated their indigent health care systems through contracts with HMOs which are required to bid competitively. For states such as Arizona, HMOs and fee-for-service delivery systems are clearly separate products. Moreover, Congress has encouraged the use of managed care programs in the Medicare and Medicaid program in conjunction with the states' efforts (Pet. App. 23a).

in state policy have not been realized in north-central Wisconsin. As found by the jury, Marshfield's actions extinguishing provider competition and competition in HMO insurance products not only strike at the heart of state antitrust enforcement in local markets, they undermine Wisconsin's fifteen-year and other states considerable efforts to create a workably competitive environment for unique HMO insurance products.

If the evidence of collusive anticompetitive acts and control over insurer choice and price admitted at trial is insufficient to support the jury's decision, as the court of appeals held, it will be extremely difficult for state and federal antitrust enforcers to maintain competition in health care markets. In fact, if juries are not allowed to decide health care antitrust cases on the facts, it could be argued that other industries are subject to this same vulnerability. If an HMO cannot, on any set of facts, be a separate product market, then protecting competition between HMOs may become virtually impossible. The court of appeals' action could have dangerous consequences for antitrust enforcement in general. For these reasons, the Amici States support the petitioners' contention that the decision of the court of appeals should be reviewed.

SUMMARY OF REASONS CERTIORARI SHOULD BE GRANTED

The attorneys general ask the Court to grant the petition for certiorari for the following reasons:

1. This Court has repeatedly held that the definition of markets in antitrust cases should be based on

facts. *E.g.*, *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 482 (1992), *citing*, *United States v. Grinnell Corp.*, 384 U.S. 563, 572 (1966) (factual inquiry into "commercial realities" faced by consumers required for proper market definition). *See also Brown Shoe v. United States*, 370 U.S. 294 (1962) ("practical indicia" standard adopted). The court of appeals not only departed from that standard, it did so in an astonishingly cavalier manner. The court of appeals substituted rigid economic theories for the conclusions of the finder of fact with but a casual reference to "contemporary principles" of antitrust analysis (Pet. App. at 3a) and without any citation to this Court's precedents.

The trial court refused to second-guess the jury's findings when it concluded that "[f]rom all of this [evidence] the jury could have reasonably determined that an HMO is a distinct and unique form of health care financing for which a relevant product market exists" (Pet. App. at 24a). In short, the court of appeals violated this Court's established standards by taking the issue of product market definition from the jury and substituting its economic predilections for the facts. *See, e.g.*, *Kodak*, 504 U.S. at 454-55, 466-68.

2. The court of appeals' decision is also erroneous because it ignores the effect of federal and state law and policy on market definition. Petitioners presented significant evidence relevant to market definition including, especially, Wisconsin and federal statutes and policies designed to create a competitive environment conducive to the creation of HMO insurance products. In effect, these state regulations differentiate the underlying cost structure of HMOs from other health insurance products. The jury and trial judge recognized that this evidence was important (Pet. App. at 23a). The court of appeals' studied avoidance of this

evidence is inconsistent with this Court's view that the regulatory environment of markets is relevant to market definition. *E.g.*, *United States v. Connecticut Nat'l Bank*, 418 U.S. 656 (1974).

3. The court of appeals decided, as a matter of law, that a plethora of anti-competitive conduct by the defendants, taken singly or together, was not sufficient to allow a jury to consider either Section 1 or Section 2 Sherman Act claims. Although ignoring much of the evidence supporting the jury findings of conspiracy and anticompetitive effect, the court of appeals conceded evidence in the record:

> --that respondent Marshfield Clinic had entered into *per se* illegal market allocation agreements with other physician groups in north central Wisconsin:
>
> --that Marshfield physicians prevented competing physicians from obtaining privileges at the key hospital in the area and that Marshfield physicians wilfully refused to provide cross-coverage for physicians unwilling to adhere to Marshfield's HMO scheme;
>
> --that there was substantial evidence of price-fixing allowing Marshfield to achieve "most favored nation" status vis-a-vis hundreds of otherwise independent physicians; and
>
> --that Marshfield physicians acted in concert with other physicians and hospitals with the express purpose of foreclosing entry by competing HMO insurers.

Clearly, the evidence in the record was sufficient to allow the jurors to find antitrust violations, and they in fact did so. The court of appeals' rejection of the jury's findings is inconsistent with this Court's precedents. *See, e.g., Kodak*, 504 U.S. at 454-55, 466-68 (1991); *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (agreement by dentists to withhold x-rays could constitute Section 1 violation).

ARGUMENT

I. THE COURT OF APPEALS' DECISION CONFLICTS WITH DECISIONS OF THIS COURT BY SUPPLANTING THE FACTUAL BASIS FOR MARKET DEFINITION.

Fourteen years ago, this Court determined that the health care industry would not be afforded any special exemptions or immunities from the national policy favoring competition embodied in the Sherman Act. *See Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). Subsequent decisions of this Court have underscored the applicability of federal antitrust laws to a variety of conduct tending to subvert competitive health care markets. *E.g., F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986). Rather than apply these precedents to the facts of this case, the court of appeals made sweeping generalizations about health insurance markets and about anticompetitive practices by dominant health care providers. As a result, the far-

reaching rhetoric of the court of appeals decision will prevent lower courts from correctly applying Supreme Court precedent in a wide variety of new cases.

Subsumed in the substantive issues presented for review is, perhaps, the more fundamental question of the proper role of the trier of fact in resolving basic factual issues. The court of appeals, unlike the trial court, did not leave the credibility of witnesses or the weight of the evidence for the jury.[7] Nor did the court of appeals accept that the evidence presented created at least a question of fact on product market definition. Instead, the court of appeals substituted its judgment for that of the jury on this key issue notwithstanding this Court's precedents. *Kodak* instructed that where doubt is present regarding a product market definition issue, the issue "should be resolved by the trier of fact." 504 U.S. at 463.[8] Further, the approach of the court of appeals in rejecting *all* of the evidence suggesting a separate HMO product market (Pet. App. at 7a) directly contradicts the approach of other courts of appeal which have held that relevant market definition is a finding of fact subject to the "clearly erroneous" standard. *E.g.*, *United States v. Central State Bank*, 817 F.2d 22, 24 (6th Cir. 1987); *Westman Comm'n Co. v. Hobart Int'l Inc.*, 796 F.2d 1216, 1220 (10th Cir. 1986), *cert. denied*, 486 U.S. 1005 (1988);

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[7] The author of the court of appeals' decision is on record as questioning the ability of juries to decide antitrust cases. R. Posner, *Antitrust Law, An Economic Perspective* 235 (1976).

[8] This Court also stated in *Kodak* that on a motion for summary judgment the nonmoving party's inferences need only be "reasonable" in order to reach a jury. 504 U.S. at 468-69, distinguishing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

Fishman v. Estate of Wirtz, 807 F.2d 520, 531 (7th Cir. 1986).

A. Even considering only those facts that the court of appeals conceded were supported in the record, the jury should have been permitted to find an HMO market as it, in fact, did.

Product market definition is not an exact science. In determining which products compete with each other, economists traditionally assess the degree to which products are interchangeable in use and the degree to which consumers are willing to substitute one product for another. Because these issues are intensely fact-bound, this Court has traditionally looked to "practical indicia" of competing products when defining markets for antitrust cases. *E.g.*, *United States v. Grinnell Corp.*, 384 U.S. 563, 572 (1966); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

More recently, this Court declared that "proper market definition in this case can be determined only after a factual inquiry into the 'commercial realities' faced by consumers." *Kodak*, 504 U.S. at 482. *See also United States v. E. I. DuPont deNemours & Co.*, 351 U.S. 377 (1956) (Section 2 monopolization case). The "Supreme court has wisely recognized there is 'some artificiality' in any boundary but that 'such fuzziness' is inherent in bounding any market." Areeda, Hovenkamp & Solow, Antitrust Law, volume IIA, ¶ 530D at 154 (1995).

Devoid of citation to any of this Court's authority on product market definition, the court of appeals' decision overturned a jury finding which the trial judge had found to be supported, amply, by numerous facts admitted into evidence. *Blue Cross* (Pet. App. at 7a), *rev'g* (*id.* at 24a). In so doing, the court of appeals has created a precedent that will make it extremely difficult for plaintiffs to define viable product markets.

The Court should grant the petition for *certiorari* to ensure that the courts apply the correct standard for product market definition. In this case, facts conceded by the court of appeals should have been sufficient to permit a jury to find a product market where:

> --buyers perceive HMOs as a distinct health insurance product;
>
> --sellers recognize HMO products as distinct from other health insurance products;
>
> --high prices and profit margins have persisted over time with respect to HMO insurance products; and
>
> --exclusionary conduct has been directed at potentially competing HMOs, but not at other types of health insurance products.

"From all of this the jury could have reasonably determined that an HMO is a distinct and unique form of health care financing for which a relevant product market exists." *Blue Cross* (Pet. App. at 24a).

In effect, the court of appeals categorically concluded that "practical indicia" could never support a separate product market for HMOs. *Blue Cross* (Pet. App. at 7a). Not only did the court of appeals ignore key facts relating to product market definition,[9] but, even more troubling, the court of appeals recited and then disregarded a litany of facts which would clearly have met this Court's standard of "practical indicia" of a separate product market for HMOs. At a minimum, the market definition issue was appropriately one for the jury.

Instead, the court of appeals consistently interprets facts -- such as buyer perceptions that HMOs are fundamentally different than other health insurance products -- to fit its ultimate conclusion.[10] Moreover, the court of appeals makes no attempt to place any of the facts in the record, such as buyer perceptions, in the context of this Court's decisional law. For example, supermarket grocery stores with virtually unlimited choices (analogous to traditional fee-for-service health insurance) were found to be not effectively constrained in price by "mom and pop" grocery stores that offered a more limited choice of the same goods and services. *California ex rel. Van de Kamp v. American Stores*, 697 F. Supp. 1125y, 1129 (C.D. Cal. 1988),

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[9] For example, see discussion in Section I(B), below.

[10] To give but one example, the court of appeals *ad hoc* assertion that HMOs are not a separate product but just "a method of pricing medical services," *Blue Cross* (Pet. App. at 3a) is inconsistent with the court of appeals' own observation that "many people don't like them [HMOs] because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service since, as we said, the marginal revenue of a medical procedure to an HMO is zero." *Id.* at 5a.

aff'd in part, rev'd in part, 872 F.2d 837 (9th Cir. 1989), *rev'd for failure to order divestiture*, 495 U.S. 271 (1990).[11]

One may debate whether the "practical indicia" support the conclusion that supermarkets and "mom and pop" stores are or are not in the same product market. However, under this Court's precedents, one cannot conclude as a matter of law that they are in the same product market and disregard all competing evidence and inferences suggesting otherwise. Yet, that is exactly what the court of appeals has done with respect to HMO and non-HMO insurance products.

Not only do buyers perceive HMOs as distinct products, sellers also recognize HMO products as distinct from other health insurance products. The court of appeals acknowledged the evidence of exclusionary conduct that had the purpose and effect of preventing Marshfield Clinic physicians from dealing with competing HMOs, although not other health insurance products. This Court has held that exclusionary conduct designed to prevent competition in a particular market is evidence of a separate market; such

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[11] In discussing the *American Stores* decision, Areeda, Hovenkamp and Solow observed that:

> Neither the court nor the defendant's documents saw close competition for supermarkets from "mom and pop" stores, convenience stores, gasoline stations, and other retailers who commonly sold a limited number of grocery items even though such stores (a) often matched supermarket prices on certain items and (b) might constrain very large price increases by supermarkets.

Areeda, Hovenkamp & Solow, Antitrust Law, volume IIA, ¶ 565 at 276 n.5 (citing *American Stores*).

practices would not be needed if competitive products could be created without such exclusionary conduct. *See Kodak*, 504 U.S. 479-81.

The court of appeals also did not dispute evidence that the respondent clinic refused to allow its physicians to "cross-cover" with independent physicians; discouraged hospitals that it controlled from joining competing HMOs; and restricted staff privileges of independent physicians at hospitals it controlled (Pet. App. at 12a-13a). In short, this exclusionary conduct supplemented the other evidence demonstrating that sellers in this market perceived HMOs as a fundamentally different product. *See generally* Areeda, Hovenkamp & Solow, Antitrust Law, volume IIA, ¶ 524a at 133 (1995).[12]

This Court should grant the petition for *certiorari* to clarify the correct standard for product market definition in general and as applied in this case on facts.

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[12] The court of appeals also acknowledged, then ignored, other evidence relevant to market definition. For example, it was undisputed that respondent HMO charged prices (and realized profits) far in excess of other Wisconsin HMOs because it faced no competition from competing HMOs. *Blue Cross* (Pet. App. at 9a; Tr. 1119-22). While not conclusive, this fact is one of the indicia that can support, along with the other facts, an appropriate market definition and the existence of market power. *See generally United States v. Aluminum Co. of Am.*, 148 F.2d 416 (2nd Cir. 1945). *See also* Areeda, Hovenkamp & Solow, Antitrust Law, volume IIA, ¶ 515 (1995).

B. Wisconsin statutes and policies singling out HMOs should be considered when defining health care product markets.

This Court has long analyzed state and federal regulatory frameworks when defining a product market because such frameworks often circumscribe the choices consumers can make and the terms of competition and costs facing sellers. *E.g.*, *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 665 (1974). *See also United States v. Household Fin. Corp.*, 602 F.2d 1255, 1258-9 (7th Cir. 1979), *cert. denied*, 444 U.S. 1044 (1980). Consistent with these precedents, the district court and jury examined the state and federal regulatory framework when addressing product market definition. *Blue Cross* (Pet. App. 23a-26a). The petitioners' expert witnesses cited federal and state laws that distinguish HMOs from standard health care insurance on both the buyer and seller side of the market. The district court and jury weighed this evidence with the other practical indicia to determine that a relevant product market existed. (*Id.* at 23a.) In direct contrast, one looks in vain for any discussion of these facts in the court of appeals decision.

Where anticompetitive conduct targets HMO growth, the relevance of policies designed to encourage the growth of HMOs is heightened. The conduct at issue here is the latest example of the ability of health care providers to thwart the emergence of unique health care products. Because HMOs are fundamentally different from traditional health insurance plans, physicians have historically rejected the control over physician practice represented by HMOs. *See generally F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986);

Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982). In part to overcome this resistance, the federal and state legislatures have attempted to alter the economics of health care markets. For example, Congress' requirement that employers with more than 25 employees offer a qualified HMO plan directly increases demand for HMOs and decreases the substitutability of other health insurance plans for HMOs.[13]

Similarly, regulation has changed the underlying economics of HMOs from the perspective of health care insurance sellers. For example, as articulated by the trial court, Pet. App. 24a, Wisconsin has adopted statutes regarding HMOs that create a unique economic environment or cost structure for HMOs. For example, Wisconsin statutes set out unique capital requirements, Wis. Stats. §§ 609.96, 613.19 (1993-94), and unique treatment under Wisconsin's guaranty fund. Wis. Stat. § 646.11(2) (1993-94). In addition, Wisconsin has adopted programs which either by choice or mandate will place an increasing percentage of the Medicare and Medicaid population into HMOs. *See generally* Wis. Stats. § 49.45 (1993-94).

The court of appeals' treatment of the product market issue undermines the efforts of Congress, Wisconsin and other states[14] to support and promote HMO insurance products.

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[13] Wisconsin has also attempted to promote HMOs by requiring that state employees be offered HMO and non-HMO alternatives. Wis. Stat. § 40.51(6) (1993-94).

[14] *E.g.*, Fla. Stat. Ann., §§ 641.17 *et seq.* (West 1984; Supp. 1995); Ill. Ann. Stat., *ch.* 215, ¶ 125 (Smith-Hurd 1993); Md. Health-Gen. Code

(continued...)

Indeed, with its product market decision, the court of appeals has opened the way for a series of consolidations that could significantly eliminate competition among HMOs and between HMOs and traditional health insurance plans.

This Court should grant the petition for *certiorari* to establish the appropriate weight state and federal law and policy should be given in determining market definition and market power.

II. THE COURT OF APPEALS' REJECTION OF ANY CAUSE OF ACTION UNDER THE SHERMAN ACT CONFLICTS WITH THE DECISIONS OF THIS COURT.

The court of appeals decided, as a matter of law, that a plethora of anticompetitive conduct by the defendants, taken singly or together, was not sufficient to allow a jury to consider either Section 1 or Section 2 Sherman Act claims. Unfortunately, the court of appeals did not articulate a meaningful standard against which this conduct could be evaluated, much less a standard consistent with this Court's precedents. *See, e.g., F.T.C. v. Indiana Fed'n of Dentists,* 476 U.S. 447 (1986) (agreement by dentists to withhold x-rays could constitute Section 1 violation).

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[14](...continued)
Ann. § 19-702 (1990); N.Y. Pub. Health Law, §§ 4400 *et seq.* (McKinney 1985; Supp. 1996). *See* Jon B. Christianson, *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991) (forty-six states have HMO statutes).

As was the case with the market definition issue, the court of appeals ignored much of the evidence supporting the jury's findings of conspiracy and anticompetitive effect. But even if one simply considers the evidence conceded by the court of appeals, it is clear that the court of appeals substituted its "skepticism," boldly wrapped in its rhetoric of "contemporary antitrust principles," *Blue Cross* (Pet. App. at 3a), for application of this Court's precedents. In addition to conceding the fact, and affirming the jury's finding that respondent Marshfield Clinic had entered into *per se* illegal market allocation agreements with other physician groups in north central Wisconsin (*id.* at 18a), the court of appeals conceded that there was evidence in the record:

> --that Marshfield physicians prevented competing physicians from obtaining privileges at the key hospital in the area;
>
> --that Marshfield physicians wilfully refused to provide cross-coverage for physicians unwilling to adhere to Marshfield's HMO scheme;
>
> --that there was substantial proof of price-fixing allowing Marshfield to achieve "most favored nations" ("MFN") status vis-a-vis hundreds of otherwise independent physicians; and
>
> --that Marshfield physicians acted in concert with other physicians and hospitals with the express purpose of foreclosing entry by competing HMO insurers.

However, the court of appeals does not discuss the extensive factual findings in the trial court record concerning these anticompetitive practices (Pet. App. at 32a-37a).

Notwithstanding this litany of anticompetitive and conspiratorial acts, the court of appeals is curtly dismissive and fails to even cite relevant authority of this Court. The treatment of most favored nation ("MFN") clauses is but one example of this. Although in *Connell Construction Co. v. Plumbers & Steamfitters Loc. Union No. 100*, 421 U.S. 616, 623-24 (1975) this Court recognized the anticompetitive effects of MFN clauses, the court of appeals expresses the view that MFN clauses are virtually always procompetitive (Pet. App. at 16a-17a).

Indeed, the court of appeals failed to put MFN issue in context by ignoring the obvious connection between the generous pricing arrangements respondent Marshfield afforded its affiliated doctors, on the one hand, and the affiliation agreements with those same doctors, on the other. In essence, respondent gave its affiliates a share of its monopoly profits but retained control over the affiliates' ability to discount to competing HMOs (Pet. App. at 31a-33a). Whether one characterizes these arrangements as classical MFNs, *de facto* MFNs, or something else, the jury was appropriately permitted to consider this evidence. Indeed, the court of appeals' admission that respondent Marshfield's actions toward independent doctors are "ambiguous from the standpoint of competition and efficiency" (Pet. App. at 13a), underscores the lack of any basis for overturning the jury's verdict.

If these anticompetitive acts are held insufficient to support a jury decision, as the court of appeals held, it will be extremely difficult for state and federal antitrust enforcers to maintain competition in health care markets.

CONCLUSION

For the foregoing reasons, this Court should grant the petition of the petitioner for a Writ of Certiorari.

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No. 95-1118

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITIONERS' REPLY BRIEF

Although the Attorneys General of twenty-six States, including Wisconsin, as well as the largest health-insurance association in the Nation, have recognized the profound importance and potentially dire consequences of the Seventh Circuit's decision in this case,[1] respondents have attempted to describe the case as merely a private factual dispute of little import. In order to make that claim, they have misstated the holdings of the court below and mischaracterized the record evidence. Regrettably, their argument about "most favored nation" (MFN) clauses descends to *ad hominem* attacks and bald accusations of "plain fabrication" and "disturbing misrepresentation of the record." Br. in Opp'n at 1-2. This reply sets the record straight. *See* Point III.

I. THE RULINGS AT ISSUE ARE NOT FACT-SPECIFIC AND THUS WILL HAVE A BROAD IMPACT.

Rather than confront the enormous potential impact of the Seventh Circuit's decision, respondents assert that the petition "simply challenges two sufficiency determinations" and fails to raise any legal question for this Court's review. Br. in Opp'n at 11; *see id.* at 1-2, 11-15. That assertion is plainly incorrect.

Despite the Seventh Circuit's language purporting to review the record, the court's reasoning is based entirely on supposed economic laws of general applicability. Because the opinion "focuses on theoretical and legal arguments" and "does not contain the traditional apparatus of fact review," *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2591 (1993), there is no basis for distinguishing this case in some future proceeding where it is claimed that health maintenance organizations ("HMOs") are a market or that MFN

[1] *See* Br. of *Amicus Curiae* States of Wisconsin et al. at 1-5 [States' Br.]; *Amicus Curiae* Br. of Blue Cross & Blue Shield Ass'n at 1-2 [BCA Br.].

clauses are anticompetitive. (Pet. 12.) If the ruling was actually based on the absence of evidence, one would expect some discussion of the record.[2] Instead, the court held, in effect, that it does not matter what the witnesses said—theoretical laws of economics must prevail.[3]

Tellingly, respondents are unable to conjure up a single hypothetical fact-pattern in which a physician-owned HMO could be held liable, under the Seventh Circuit's reasoning, for monopolization under Section 2 of the Sherman Act, 15 U.S.C. § 2, or for an unreasonable restraint of trade under Section 1, *id.* § 1. Nor do respondents even attempt to counter Point III of the petition, which explains the potential impact of the Seventh Circuit's antitrust analysis on the future of American health care. *See* Pet. 23-29.[4] Because the court's legal pronouncements cannot be confined to *any* imaginable set of facts, and therefore will have a sweeping and adverse effect on health-care antitrust enforcement, the decision below should be reversed and the jury findings reinstated.[5]

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[2] *Cf. Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986) (summary-judgment movants bear the burden of "'showing'—that is, pointing out to the district court—that there is an absence of evidence to support the nonmoving party's case"). The Seventh Circuit's "fact-free" approach to appellate review stands in sharp contrast to the district court's extensive factfinding and review of record evidence. (Pet. App. 21a-63a.)

[3] The Seventh Circuit's elevation of theory over fact conflicts with decisions of this Court and of other Courts of Appeals. *See, e.g.*, cases cited at Pet. 13-15, 14 n.10, 22, 28.

[4] Even before the Seventh Circuit ruled, Marshfield Clinic's general counsel, Reed E. Hall, had conceded that "[t]his case will have national implications." *Suit Involving Wisconsin Clinic Has Broad Implications*, Rochester (Minn.) Post-Bulletin, Mar. 31, 1995, at 5B.

[5] On November 8, 1995—three weeks *after* modifying its opinion (Pet. App. 64a-65a)—the Seventh Circuit recognized that this case still raises "important question[s] meriting review by the Supreme Court," 7th Cir. R. 41(b)(3), and therefore stayed the mandate pending the filing and final disposition of this petition.

II. THE SEVENTH CIRCUIT DID NOT ENTER ALTERNATIVE HOLDINGS THAT WOULD REQUIRE REVERSAL OF THE TRIAL COURT'S JUDGMENT.

The structure of the opinion below (Pet. App. 1a-20a), as well as that of the special verdict form (Pet. App. 74a-76a),[6] belies respondents' claim that the Seventh Circuit made "alternative holdings" that "independently support the judgment below and would require affirmance no matter how the questions presented were decided." Br. in Opp'n at 2, 15; *see id.* at 15-18. If this Court were to reverse the decision below that no reasonable jury could have found that Security's affiliation agreements and Marshfield's broad pattern of exclusionary practices were unreasonable restraints of trade (Pet. App. 17a), the 1300 physicians employed by or affiliated with Marshfield or Security would clearly have a monopoly share even in the broader "market" defined by the Seventh Circuit (for services provided by physicians to HMO and non-HMO patients), and no issue of market definition or market power could prevent petitioners from obtaining relief.[7] And if this Court were to reverse the decision

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[6] Respondents have never raised any objection to the special verdict form or to the jury instructions regarding the antitrust laws.

[7] After stating that "work for Security generates only 6 percent of [the affiliated] physicians' total income" (Pet. App. 3a; *see* Pet. App. 65a; *see also* Br. in Opp'n at 3, 22), the Seventh Circuit elected to measure market share by reference only to the 400 physicians who own and are employed by the Marshfield Clinic, while effectively ignoring the 900 affiliates who have contracts with Security. (Pet. App. 7a; *see also* Br. in Opp'n at 16 n.13.) The 6% figure is incorrect. *See* Appellees' Pet. for Reh'g at 2-6 (citing extensive record evidence contradicting that figure); *see also* 881 F. Supp. 1309, 1313 (W.D. Wis. 1994) (denying respondents' summary judgment motion).

Moreover, the fraction of the affiliates' income derived from Security does not begin to measure their dependence on Marshfield. Marshfield—which owns or controls most of the hospitals in the region—made it clear that physicians who refused to affiliate on Security's terms would face ruinous competition, the denial of hospital staff privileges, and problems obtaining cross-coverage of

below that no reasonable jury could have found a market for HMO services in north-central Wisconsin (Pet. App. 3a-10a), Security's nearly 90% share of that market (Pet. App. 3a) would easily pass any test of monopoly power (Pet. App. 12a)—regardless of whether the Seventh Circuit's broadly defined "market" had been monopolized by Marshfield and Security.[8] Thus, review of the questions presented here certainly could result in the reversal of the Seventh Circuit's judgment and the reinstatement of the District Court's.[9]

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patients from physicians employed by Marshfield or affiliated with Security. (Pet. 5, 18-21, 27-28; Pet. App. 13a, 28a, 31a-33a, 50a-52a; Tr. 58, 201-16, 483, 713, 925-28.) Furthermore, affiliates are expected to (and do) refer their non-Security patients to the Marshfield Clinic. (Pet. App. 31a-32a; Tr. 1030, 1721; Tr. Exhs. 1841, 10361-10362.) Thus, the jury and the trial court properly concluded that the 900 affiliates, as well as the 400 Marshfield physicians, have been recruited (willingly or unwillingly) into respondents' 1300-physician cartel.

[8] Respondents' argument that Marshfield Clinic is not an "essential facility," Br. in Opp'n at 2, 7-8, 17-18, is a red herring. That issue only arises if one rejects the HMO market and then treats the affiliated physicians as separate from Marshfield. *See* Pet. App. 10a-12a (reaching the essential-facility argument only as a potential fallback *after* holding that Marshfield "is not a monopolist . . . because it does not control its independent contractors and once they are excluded, the Clinic . . . does not have a monopoly of physician services in the north central region or in any parts of the region other than parts too small to support more than a handful of physicians"). Thus, respondents are flatly wrong in stating that the Seventh Circuit's rejection of petitioners' essential-facility argument is "dispositive of all of petitioner Compcare's claims." Br. in Opp'n at 8.

[9] Respondents also misstate the court's holding on the *per se* violation of Section 1 for market division. Respondents claim the court found sufficient evidence of only "a single illegal agreement between Marshfield and the North Central Health Protection Plan" and remanded the case to the district court for a determination of damages "flowing to Blue Cross from that one agreement." Br. in Opp'n at 9-10 (citing Pet. App. 17a-19a). Actually, the court "conclude[d] that the jury verdict on liability must stand insofar as [it concerned] the charge of a division of markets . . . with

III. RESPONDENTS REPEATEDLY MISCHARACTERIZE THE RECORD EVIDENCE PERTINENT TO THE QUESTIONS PRESENTED.

Unlike the decision below, which "merely" disregarded the record evidence and bypassed "the traditional apparatus of fact review," *Brooke*, 113 S. Ct. at 2591, respondents' opposing brief goes one step further and affirmatively misrepresents the facts of the case to avoid review by this Court. *See* Br. in Opp'n at 18-23.

A. The Market for HMO Services in North-Central Wisconsin

With respect to the HMO market issue, there was ample evidence to support the jury's findings, including expert testimony to which the jury and the trial judge gave credence. (Pet. App. 23a-27a.) Respondents' *own internal documents* recognized that competition from a new *HMO* could immediately undercut Security's bloated prices by twenty percent, yet other types of health-care plans were incapable of driving down Security's prices. (Tr. Exhs. 1562, 1563; *see* Tr. 985; *see also* Pet. 3-4 n.3, 19 n.17, 27 n.31; Tr. 1118-22 (undisputed testimony showing Security charged 15% to 75% more than comparable HMOs elsewhere in the State and Nation).) Thus, contrary to respondents' spin, *see* Br. in Opp'n at 16 n.13, this is *not* a case in which defendants' inflated prices could as easily be attributed to "high quality" as to monopolization.

Moreover, as the caselaw makes clear, the mere fact that there is *some* substitutability between HMOs and other forms of health-care delivery and financing, *see* Br.

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competing *plans* or *groups*." (Pet. App. 19a (emphasis added).) The court expressly affirmed the provisions of the district court's injunction that forbade the Clinic to divide markets with the Gunderson Clinic (Pet. App. 55a), the Rice Clinic (*id.*), Wausau area physicians (Pet. App. 55a-56a), Rhinelander Medical Center (Pet. App. 56a), and the Ministry Corporation and its representatives (Pet. App. 57a), as well as the North Central Health Protection Plan (Pet. App. 56a) and "possibly others." (Pet. App. 19a.)

in Opp'n at 19-20, cannot be dispositive: unless the competition is strong enough to constrain the dominant supplier of HMO services (such as Security) from profitably raising its prices significantly above the competitive level, there is a separate product market for HMO services. (Pet. 13-16 (citing *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 481-82 (1992); *United States v. Grinnell Corp.*, 384 U.S. 563, 571-72 (1966); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325-28 (1962); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993)).)[10]

Furthermore, respondents do not even attempt to address the fact that HMOs are controlled by an entirely distinct body of state and federal regulation[11]—a factor this Court has seen as indicative of a separate market. *See United States v. Connecticut Nat'l Bank*, 418 U.S. 656, 660-66 (1974). *See generally* States' Br. at 6-7, 15-17.

Respondents also brazenly mischaracterize the petition when they claim it "ignored" the issue of supply substitution. Br. in Opp'n at 22; *accord id.* at 2, 20 n.14. As the petition explained, Pet. 17-18 & n.14, it is the very

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[10] While largely ignoring the controlling precedents of this Court, respondents cite three district court decisions from the 1980s finding insufficient proof of an HMO market. Br. in Opp'n at 13. None of those cases, however, involved an HMO owned and controlled by an organized group of physicians who were using HMO affiliation agreements and coercive tactics to bring virtually all of their competitors under one umbrella. Pet. 19; Pet. App. 31a-33a, 50a-52a; *see* BCA Br. at 8-11. The Seventh Circuit relied upon its own understanding of "contemporary principles of antitrust law" (Pet. App. 3a) and cited neither the precedents of this Court nor the district court decisions. (Pet. App. 3a-10a.)

[11] *See* Pet. 15, 16-17 & n.12; Pet. App. 23a-24a; Tr. 62, 1111, 2310; Tr. Exh. 4; *see also* 42 U.S.C. §§ 300e-9, 1395mm; 42 C.F.R. § 417.420; Wis. Stat. §§ 49.45(9), 609.96, 613.19, 646.11(2). *See generally* Jon B. Christianson et al., *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991) (at least 46 States have enacted statutes directed at HMOs).

issue of supply substitution that exposes the critical link between the two questions presented: Marshfield's predatory and concerted actions—especially its *per se* illegal division of markets and its unreasonable use of anticompetitive affiliation agreements—effectively cut off the supply of doctors and thus precluded any competing HMO, such as Compcare, from assembling a comprehensive panel of physicians who could compete effectively against Security's HMO monopoly. (Pet. App. 4a, 27a-28a, 31a-33a, 36a-37a, 50a-52a.)[12]

B. The Anticompetitive Affiliation Agreements and Related Predatory and Concerted Actions

With respect to the affiliation agreements, it is the respondents who engage in "disturbing misrepresentation of the record" when they claim—contrary to the Seventh Circuit's opinion (Pet. App. 16a-17a)—that the agreements between Security and its affiliated physicians do not contain "MFN clauses." Br. in Opp'n at 1-2. Respondents quote from—and even reproduce in an appendix, Opp'n App. 1a (Tr. Exh. 1444)—Paragraph 3.01 of the old *1989* version of the Affiliated Provider Subcontract for physicians in the Greater Marshfield sub-region. Br. in Opp'n at 21. That paragraph appears to set Marshfield's reimbursement at 85% of the provider's "usual and customary charges," which would be roughly consistent with the typical competitive HMO's willingness to reimburse physicians at no more than 80% of list price.

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[12] Respondents incorrectly suggest that all types of "network-based health plans" are "indistinguishable" and that therefore physicians already organized as a preferred provider organization (PPO) or as a point-of-service (POS) plan network could easily "convert to HMOs if it were profitable to do so." Br. in Opp'n at 20 n.14. The Seventh Circuit addressed only PPOs (Pet. App. 6a), and its reasoning is plainly incorrect. (Pet. 11 n.8, 17 n.15.) As to the POS plan, the district court expressly *rejected* respondents' argument that the single POS plan operated by petitioners was a competitive substitute for the comprehensive array of physicians required to form an HMO. (Pet. App. 27a-28a.) The Seventh Circuit did not dispute that conclusion.

(Pet. App. 36a; Tr. 2308.) However, the 1992 (and 1989) versions of the agreements for the three other sub-regions of north-central Wisconsin (NorthCare, Westwoods, and Wausau) all contain other key provisions that respondents conspicuously fail to mention. (Tr. Exhs. 1442-1443, 1527-1530.) Typical of these other provisions are Paragraph 3.02 and Amendment No. 1 of the 1992 agreement for the NorthCare sub-region. (Tr. Exhs. 1527-1528.) Those provisions give affiliates two "options": either receive 85% of "usual and customary charges" with no risk *or* accept a *de minimis* risk of uncollectibles and receive *100%* of those charges. (*Id.*) At trial, there was extensive testimony showing, not surprisingly, that affiliates *routinely* opted for and received 100% reimbursement. (Pet. App. 36a; Tr. 868-70.) Thus, the "85% clause" respondents quote in their brief was almost never invoked; it was simply camouflage for the far more important contractual provisions that respondents' brief strategically ignores.

Furthermore, Security demanded that each affiliate submit his or her fee schedule for pre-approval and, contrary to respondents' arguments, Br. in Opp'n at 22, there was *no* evidence that Security ever approved a fee schedule setting an affiliate's "usual and customary" rate above his or her "lowest" rate. Rather, as the district court found and the Seventh Circuit did not dispute, under Marshfield's scheme the affiliate had *one* price, and it applied to both Security and non-Security patients. (Pet. App. 36a; Tr. at 887-89.) That is precisely how the affiliation agreements served as tools for tacit price collusion.

Thus, the affiliation agreements—specifically, the parts respondents conveniently left out of their brief and appendix—*functioned as MFN clauses,* ensuring Security that it would be treated at least as favorably as any other HMO. *See Connell Constr. Co. v. Plumbers & Steamfitters Local Union No. 100,* 421 U.S. 616, 623-24 & n.1 (1975) (interpreting a contractual provision as a " 'most favored nation' *clause*" because trial testimony

showed that the "primary effect of the agreement" was "to inhibit the [seller] from offering any other [buyer] a more favorable contract" (emphasis added)); *see also* DOJ and FTC Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788 (Sept. 30, 1994). Tellingly, respondents *never* directly refute the Seventh Circuit's statement that Marshfield and Security "would not pay [the affiliated physicians] more than what these physicians charge their other patients." (Pet. App. 16a.)

The jury and the district judge properly found (Pet. App. 36a), and petitioners accurately argued in the Seventh Circuit, that the practical—indeed, the inevitable —result of the agreements was to stabilize prices for primary-care physician services throughout north-central Wisconsin by "establish[ing] a floor for *all* of an affiliate's charges, *not* just charges to [Security]." Appellees' Br. & Supp. App. at 15 (emphasis in original), *quoted in* Br. in Opp'n at 8-9, 9 n.6. *See generally* VI Phillip E. Areeda, *Antitrust Law* ¶ 1435e, at 229-31 (1986); Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs,* 14 Am. J.L. & Med. 147 (1988). Therefore, the question presented by the petition is correct: the affiliation agreements *did* "require[] [the affiliated] physicians to reduce their lucrative compensation from the dominant HMO [Security] if they accepted lower offers from another HMO" such as Compcare. (Pet. i.) Because the agreements facilitated tacit collusion among some 1300 physicians, created a supracompetitive price floor for medical services throughout north-central Wisconsin, restricted competition that otherwise would have forced prices to drop below that floor, and were buttressed by other predatory and concerted conduct designed to exclude competitors from Marshfield's and Security's markets, the decision below was wrongly decided.

CONCLUSION

This case is not simply a quarrel between an insurer and a group of doctors. Rather, it is a dispute concerning the grossly anticompetitive conduct of the Nation's fifth largest physician-owned clinic. And—as Attorneys General representing a majority of the States and the overwhelming majority of the American people have recognized—it is a dispute implicating the most important antitrust concerns facing American health care today. Accordingly, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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